MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 1113 7 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ----

~~XXXXXXXXXX~~ street address where death occurred:

514 Alfred Drive

How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. 514 Alfred Drive (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME CLAUDIA C. ANDERSON

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife ----

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1865

8. AGE: Years	Months	Days	If less than one day
81	1	25	____ hrs. ____ min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name David Anderson

13. Birthplace North Carolina

MOTHER

14. Maiden name Sarah Wiley

15. Birthplace North Carolina

16. Informant Miss Joanna H. Anderson

Address 514 Alfred Drive, Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16, 1946 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington, D. C.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Maryland

19. Nov. 15 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14-46 19____ at 10 35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 19____ to ____ 19____

and that I last saw h~~im~~ alive on 11-14-46. 19____

Immediate cause of death	DURATION
(a) Cerebral Hemorrhage (Stroke)	6 days
Due to (b) Old Cerebral Hemorrhage & Right Left Hemoplegia.	2yr 6 mos.
Due to (c) Generalized C.V.D. Sclerosis.	20 yrs
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Kenneth Laughlin Asst. M. D. or other

Address 8252 Georgia Ave Date signed 11-14-46.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8290

Reg. Dist. No. 11132 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45 M

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Nov. 3, 1946

Hospital, Institution, or street address where death occurred:
Suburban Hosp. - 8600 Old Georgetown Rd. Bethesda Md.

How long in hospital or institution? Since Nov. 3, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town Silver Spring Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. Grace Church Rd Extended
(If rural, give LOCATION)

(a) If veteran, name war No

3. (a) FULL NAME

Miss Willie Mae Anderson

3. (b) Social Security Number

NONE

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
F	W	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 14, 1873

8. AGE: Years	Months	Days	If less than one day
73	5	25	..... hrs. ..... min.

9. Birthplace Frederick Md. (Uncertain)
(Town, county, and state)

10. Usual occupation Household duties

11. Industry or business

FATHER
12. Name Wm. H. Anderson
13. Birthplace UnKnown

MOTHER
14. Maiden name UnKnown.
15. Birthplace UnKnown

16. Informant Marion Cecelia Williams

Address Grace Church Rd, Extended Silver Spring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9 1946 (month) (day) (year)

Cemetery or ~~crematory~~ Grace Episcopal Church.

Location Ga. Ave - Silver Spring

18. Funeral director Warner E. Pumphrey

Address Silver Spring - Md

19. 11 9 1946 Mrs E Forbes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1946, at 9:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Nov 1946, to 7 Nov 1946 and that I last saw h. alive on 7 Nov 1946

Immediate cause of death	DURATION
(HYPOSTATIC) PNEUMONIA, unresolved	3 days
Due to Generalized debility & senility & Malnutrition	
Due to	
Other conditions Acute pericarditis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Unresolved pneumonia, pleural effusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. N. Lebensohn M. D.
M. D. or other

Address Suburban Hosp. Bethesda - Md Date signed 7 Nov 1946

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11133

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

12/16/46

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 113

Hospital, institution, or street address where death occurred:
U.S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 113

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Conn. County:

City or town: New London
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 311 Huntington Street
(If rural, give LOCATION)

2.(a) If veteran, name war: U.S. Navy (C)

3.(a) FULL NAME: ANELLO, Ronald Joseph S 2/c USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 24 December 1927

8. AGE: Years	Months	Days	If less than one day
18	11	6	hrs. min.

9. Birthplace: New London, Conn.
(Town, county, and state)

10. Usual occupation: U.S. Navy

11. Industry or business:

FATHER
12. Name: Louis Anello
13. Birthplace: Italy

MOTHER
14. Maiden name: Rose Proto
15. Birthplace: Italy

16. Informant: Mrs. Rose Anello Conn
Address: 311 Huntington, St., N. London

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-3-46 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: W.W. CHAMBERS
Address: 517 Eleventh St. S.E.

19. 30 November 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 November 1946 at 1:15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Aug. 1946, to 30 Nov. 1946 and that I last saw him alive on 30 November 1946

Immediate cause of death	DURATION
Meningitis, tuberculous	4 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: Meningitis, tuberculous

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P. F. DICKENS, Jr. Comdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-30-46

2-25

2-2160 — 2-10

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Diat. No. 11134 241 0

1. PLACE OF DEATH:

County Montgomery

City or town Brownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Dr. Damascus

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME mary maud Ashton

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 30 1885.

8. AGE: Years	Months	Days	If less than one day
60	10	5	hrs. min.

9. Birthplace montgomery county (Town, county, and state)

10. Usual occupation Retired school teacher

11. Industry or business

FATHER 12. Name John Wesley Ashton

13. Birthplace Virginia

MOTHER 14. Maiden name Susan E. Lawson

15. Birthplace maryland.

16. Informant Mrs. Herbert Burdette

Address Clarksburg, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6 1946 (month) (day) (year)

Cemetery or crematory Bethesda Cemetery

Location Brownsville md

18. Funeral director J. B. Beall, Inc.

Address Damascus md.

19. Nov 6 (Date rec'd by registrar) 19 46 Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1946, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27, 1946, to November 4 1946.

and that I last saw h. F.P. alive on November 3 1946.

	DURATION
Immediate cause of death Coronary occlusion	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE James P. Kerr M.D. M. D. or other

Address Damascus, Md. Date signed 11/6/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

11135

Reg. Dist. No. 217 0

1. PLACE OF DEATH:
County Montgomery
City or town Brown's Corner — Edno P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Agnes Billows

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Col.	widowed

8.(b) Name of husband or wife Singleton Billows
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1893

8. AGE: Years	Months	Days	If less than one day
53			hrs. min.

9. Birthplace (Town, county, and state)
10. Usual occupation House keeper.
11. Industry or business

FATHER
12. Name Cornelius Awkward
13. Birthplace md

MOTHER
14. Maiden name Rozena Bacon
15. Birthplace md

16. Informant Corrie Johnson (Daughter)
Address Browns Corner, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 24 1946 (month) (day) (year)
Cemetery or crematory Sandy Spring Cem.
Location Sandy Spring, Md.

18. Funeral director R. L. Anderson
Address Rockville, md.

19. 11-24-1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1946, at 4:17 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1938, to November 21 1946
and that I last saw her alive on November 20 1946

Immediate cause of death Arteriosclerosis Coronary Occlusion — DURATION
Due to General Arteriosclerosis
Due to Hypertensive cardio renal Disease — 1938
Other conditions Psychosis Senile
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Webster Sewell M.D.
M. D. or other
Address Norbeck, Md. Date signed Nov 23 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 11136

Reg. Dist. No. 2180

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2Yr 10 Mo

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 2 yr 10 Mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montg

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Miss Bessie Belle Botts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 9th 1861

8. AGE: Years	Months	Days	If less than one day
1861 84	11	15	..... hrs. ..... min.

9. Birthplace: Culpepper. Va,

(Town, county, and state)

10. Usual occupation: House Work

11. Industry or business: "

FATHER — 12. Name: William Botts

13. Birthplace: Va.

MOTHER — 14. Maiden name: Maria Kemper

15. Birthplace: Va,

16. Informant: Methodist Home, H M Wilson

Address: Gaithersburg. Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/27/46 (month) (day) (year)

Cemetery or crematory: Cedar Grove Cemetery

Location: Bealeton. Va,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md,

19. Nov. 26 1946 (Date rec'd by registrar) Abuda G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24th 1946 at 11.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 1946 to Nov - 24 - 1946

and that I last saw h.. alive on Nov - 24 - 1946

Immediate cause of death: (a) Uraemic Poisoning — DURATION: 6 mo -

Due to: (b) Cardio-nephritis

Due to: (c)

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William E. Riley M.D. M. D. or other

Address: Gaithersburg, Md. Date signed 11/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131b

11137

CERTIFICATE OF DEATH

Reg. Dist. No. 2170

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: The Montgomery County General Hospital Inc.

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Brookeville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Warner Brogden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 3, 1875

8. AGE: Years 70 | Months 11 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Edward Brogden

13. Birthplace Maryland

MOTHER 14. Maiden name Jane Lee

15. Birthplace Maryland

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25, 1946 (month) (day) (year)

Cemetery or crematory Church Cemetery

Location Mt. Zion, Md.

18. Funeral director R. L. Snowden

Address Rockville, Md.

19. 11-25 1946 Gertrude B. Lawlor

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1946 at 5:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16 1946, to November 23 1946

and that I last saw him alive on November 23 1946

	DURATION
Immediate cause of death Uremia	4 months
Due to Chronic nephritis	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard A. Yates M.D. M. D. or other

Address Sandy Spring, Md Date signed 11/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

1138

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Few minutes
Hospital, institution, or street address where death occurred: electric pole
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)
Street No. R#4 Near Oakdale (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Tarlton Brooke

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mrs. Eloise Brooke
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 18, 1881

8. AGE: Years	Months	Days	If less than one day
65	9	17	hrs. min.

9. Birthplace: Norbeck, Maryland. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: —

FATHER
12. Name: Albert Brooke
13. Birthplace: Norbeck, Maryland.

MOTHER
14. Maiden name: Sadie Pleasants
15. Birthplace: Richmond, Virginia

16. Informant: MRS ELOISE PLEASANTS BROOKE
Address: OAKDALE - MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof NOV. 7 1946 (month) (day) (year)
Cemetery or crematory: FRIENDS CEMETERY
Location: SANDY SPRINGS - MONTG CO. MD
18. Funeral director: Warner E Pumphrey
Address: SILVER SPRING - MD.

19. NOV. 7 1946 (Date rec'd by registrar) Gertrude B. Lawson Registrar

Burial permit issued in Silver Spring

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 5 1946, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3 1946 to Dec. 5 1946 and that I last saw h alive on Nov. 5 1946

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bosshart M.D. M. D. or other
Address: Gaithersburg Md Date signed 11-5-46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

STATE OF MARYLAND—CERTIFICATE OF DEATH

11139

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

S. No. 1

1. PLACE OF DEATH 47d X

County Montgomery Registration Dist. No. 7160

Village or City Bethesda No. Suburban Hospital St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. If of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME EDNA M. BROWN If U. S. Veteran, specify WAR no

(a) Residence: No. 9303 Columbia Blvd ~~St.~~ ~~Ward.~~ Silver Spring, Md.

(Usual place of abode) ~~If nonresident give city or town and State~~

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day, and year) Aug. 31st. 1896

7. AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
50	2	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Selma, Kansas

FATHER

13. NAME August J. Anderson

14. BIRTHPLACE (city or town) (State or country) Sweden

MOTHER

15. MAIDEN NAME Emma Thorstenberg

16. BIRTHPLACE (city or town) (State or country) Saline Co. Kansas

17. INFORMANT Mr. Roland H. Brown

(Address) 9303 Col. Blvd.

18. BURIAL, CREMATION OR REMOVAL

Place Fort Lincoln Cemetery Date 11-9-1946, 19

19. UNDERTAKER Warner E. Pumphrey

(Address) Silver Spring, Md.

20. FILED 11/13 1946 Wm E Jobes Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November (Month) 6 (Day) 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from October 20, 1946, to Nov 6, 1946

I last saw her alive on Nov. 6, 1946; death is said to have occurred on the date stated above, at 12 mdnt

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Date of onset

Carcinoma of Lung 1946

metastases to Brain

Other Contributory Causes of Importance:

Name of operation — Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury ____, 19

Where did injury occur? —

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? —

If so, specify —

(Signed) W B Warder M. D.

(Address) 943 Bonifant St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

Mrs. Sheppe

S. S.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ 11140

Reg. Dist. No. 3140

1. PLACE OF DEATH:
County MONTGOMERY
City or town CHEVY CHASE MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HERBERT SWIFT BUCKLEY

3.(b) Social Security Number 577-03-3215

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife IONE G. BUCKLEY (NEE GUITARD) 6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) MAY 15, 1874

8. AGE: Years 72 | Months 6 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace WASSAIC NEW YORK
(Town, county, and state)

10. Usual occupation DET

11. Industry or business

FATHER
12. Name LEWIS BUCKLEY
13. Birthplace CONN

MOTHER
14. Maiden name ABIGAIL SWIFT
15. Birthplace CONN

16. Informant MRS IONE G BUCKLEY (WIFE)
Address 5618 WISC. AVE CHEVY CHASE, MD

17. Burial (Burial, cremation, or removal, Which?) Date thereof Nov 21-46 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Md.

18. Funeral director J.W. Chambers Co.
Address 3072 M St. N.W. Washington, D.C.

19. Nov. 18 1946 (Date rec'd by registrar) Josephine McShaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1946 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 12 1946 to Nov. 18 1946 and that I last saw him alive on November 17 1946.

Immediate cause of death	DURATION
Chronic nephritis	2 yrs.
Due to Generalized arterio-sclerosis	5 years
Due to	
Other conditions Chronic congestive heart failure. (Include pregnancy within 3 months of death)	5 yrs.

Major findings of operations none Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Francis P. Hannan M.D.
M. D. or other
Address 1511-17 H St. N.W. Date signed Nov. 18, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

1114i

CERTIFICATE OF DEATH

Reg. Diat. No. 2170

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Dur.
How long in hospital or institution? 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 141 Garrett Park Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Patricia Jeanne Burdette

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 18, 1946

8. AGE: Years | Months | Days 12 | If less than one day hrs. min.

9. Birthplace Olney, Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name James Dalrymple Burdette
13. Birthplace Kensington, Maryland.

MOTHER
14. Maiden name Mary Louise Keys
15. Birthplace Rectortown, Virginia

18. Informant Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-30-1946 (month) (day) (year)
Cemetery or crematory
Location Kensington Md.

18. Funeral director W. K. Burdette
Address Hyattstown Md.

19. 11-30- 1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1946 at 5:15A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 18 1946 to November 30 1946 and that I last saw her alive on November 30 1946

Immediate cause of death	DURATION
Jaundice	
7 months	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Sandy Spring Md Date signed 11/30/46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 11142

Reg. Dist. No. 2130

1. PLACE OF DEATH:
County Montgomery
City or town Darnestown, md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Darnestown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma E Butler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	widow

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 4 1869

8. AGE: Years 77 | Months | Days | If less than one day hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name John Bell
13. Birthplace md

MOTHER 14. Maiden name Ellen Johnson
15. Birthplace md

16. Informant William Butler
Address Darnestown, md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 29 1946 (month) (day) (year)
Cemetery or crematory Montevideo
Location Montevideo, md.

18. Funeral director Robert L. Snowden
Address Rockville, md

19. 11-29 1946 (Date rec'd by registrar) Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1946, at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3rd 1946 to Nov 25 1946
and that I last saw h alive on 19

Immediate cause ui death	DURATION
Carcinoma of stomach	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jno J Bouhaut M. D. M. D. or other
Address Gaithersburg md Date signed 11-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1143

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Maryland
(If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death? 2 mo. 5 da

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 2 mo - 5 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2013 New Hampshire Ave., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME

Carey, Mrs. Julie Wilhelmina

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Caus.	Widowed

6.(b) Name of husband or wife: William Carey
(deceased) 6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 4, 1900

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
46	1	12		

9. Birthplace: Richmond, Virginia
(Town, county, and state)

10. Usual occupation: Retired Clerk

11. Industry or business: .....

FATHER — 12. Name: George Lipscomb

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Margaret Burns

MOTHER — 15. Birthplace: Ireland

16. Informant: Washington Sanitarium + Hospital Records
Address: Takoma Park, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 19-1946 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Washington, D. C.

18. Funeral director: The D J Hines Co.

Address: 2901 - 14th St. N.W.

19. Nov. 16 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16, 1946, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 11, 1946, to Nov. 16, 1946 and that I last saw h.e.r. alive on Nov. 15, 1946

Immediate cause of death	DURATION
Congestive Cardiac Failure	3 days
Due to: Acute State	1 wk
Due to: Arteriosclerosis	4 years
Due to: Hypertension, Malignant	1 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert A Stare M.D.
M. D. or other

Address: Takoma Park, Md. Date signed 11/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-14)

CERTIFICATE OF DEATH

11144

Reg. Dist. No. 216 1

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2218 Minnesotta Ave., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd World War (S) ✓

3.(a) FULL NAME: CLARKE, William Howard, VAP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Blanche Clarke

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1 Feb. 1923

8. AGE: Years	Months	Days	If less than one day
23	9	28	..... hrs. ..... min.

9. Birthplace: N.Y.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER
12. Name: Howard Clarke
13. Birthplace: unknown

MOTHER
14. Maiden name: Emma Blood
15. Birthplace: unknown

16. Informant: wife: Mrs. Blanche Clarke
Address: 2218 Minnesotta Ave., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-2-46 (month) (day) (year)

Cemetery or crematory: Arlington

Location: Arlington, Va.

18. Funeral director: W. W. Chambers (Room.)

Address: 517 11th St., S. E., Wash., D.C.

19. 11-29 1946 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 November 1946 at 1:35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Nov. 1946 to 29 Nov. 1946 and that I last saw him alive on 29 Nov. 1946

	DURATION
Immediate cause of death: Congestive failure	18 days
Due to: Congenital heart disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: communication from base of aorta through septum of heart to rt. ventricle

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. W. Thompson
C. W. THOMPSON
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

12/6/46

2-25-

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

1114

Reg. Dist. No. 212

1. PLACE OF DEATH:

County: Montgomery

City or town: Sta Teresa Via Dickerson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Martinsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Annie Laura Coleman.

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	widowed

6.(b) Name of husband or wife: Wesley Coleman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE: Years: 57 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Martinsburg Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Charles F. Coleman

FATHER — 13. Birthplace: Martinsburg Md.

MOTHER — 14. Maiden name: Harriet Shugi

MOTHER — 15. Birthplace: Martinsburg Md.

16. Informant: Mrs Morella Cores

Address: Sellman Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/19/46 (month) (day) (year)

Cemetery or crematory: Martinsburg

Location: Near Dickerson

18. Funeral director: Clarence H. Davis

Address: Poolesville Md.

19. Nov. 19 19 46 (Date rec'd by registrar) H. Clarke Gilpin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 - 19 46, at 12 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 19 46 to Nov 16 19 46 and that I last saw h alive on Nov. 16 19 46

Immediate cause of death	DURATION
Congestive Heart Failure	2 mos.
Due to: Arteriosclerosis of Coronary Arteries	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: Albert K. Golen M. D. or other

Address: Poolesville Md Date signed: NOV 18 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 — 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

★11146

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Manor Club - Rte.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Mrs. Mildred P. Covert.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Mr. Walter A. Covert.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 16, 1897

8. AGE:	Years	Months	Days	If less than one day
	49	4	22	..... hrs. ..... min.

9. Birthplace Caney Springs, Tennessee (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Mr. Austin T. Powell
13. Birthplace Caney Springs, Tennessee
MOTHER
14. Maiden name Mamie Powell
15. Birthplace Chapel Hill, Tennessee

18. Informant Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 10 - 1946 (month) (day) (year)
Cemetery or crematory Salem
Location Brookeville - Montg Co. Md
18. Funeral director Edna E. Pumphrey.
Address Silver Spring, Md

19. Nov. 9 1946 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

Permit issued at Silver Spring.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1946, at 6:40 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1943, to November 8 1946 and that I last saw h.ex alive on November 8 1946

Immediate cause of death	DURATION
Carcinomatosis	
Due to Carcinoma of right breast	3 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE [signature] M. D. or other
Address Sandy Spring, Md Date signed 11/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

2-35

11147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9a)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-46 M

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 11-3-46 - 2:45 A.M.

Hospital, Institution, or street address where death occurred:
Suburban Hosp. - 8600 Old Georgetown Rd.,

How long in hospital or institution? Since 11-3-46 - 2:45 A.M.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4506 Avondale St.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Phineas h. Crandall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
M	W	

6.(c) If alive, give age ..... years

B.(b) Name of ~~husband~~ or wife Julia Crandall

7. Birth date of deceased (mo., day, yr.) April 4, 1883

8. AGE: Years	Months	Days	If less than one day
63	7	4	..... hrs. ..... min.

9. Birthplace Hornell, New York
(Town, county, and state)

10. Usual occupation Real estate dealer

11. Industry or business

FATHER
12. Name Leonard Crandall
13. Birthplace N. York State

MOTHER
14. Maiden name Jenny Lind
15. Birthplace N. York State

16. Informant Mrs. Julia Crandall

Address 4506 Avondale St. Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/12/46 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Washington, D. C.

18. Funeral director Wm Reuben Humphreys

Address Bethesda, Maryland

19. 11/9 1946 (Date rec'd by registrar) Wm E Darby Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 19 46, at 3:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1944, to November 1946

and that I last saw h.im alive on November 7 1946

Immediate cause of death	DURATION
Coronary Thrombosis	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Bruce Benjamin M.D.
M. D. or other

Address Bethesda 14 Md Date signed 11/8/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11148

Reg. Dist. No. 2230

2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr. 45 min.

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 1 hr. 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: Alexandria

City or town: Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1600 Fitzgerald Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME

~~Unnamed Baby Boy~~ Lewis, Richard Crowder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): November 4, 1946

8. AGE: Years	Months	Days	If less than one day
			1 hrs. 52 min.

9. Birthplace: Takoma Park, Md.

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Herbert Madison Lewis

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Beth May Crowder

15. Birthplace: Washington, D.C.

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Md.

17. Removal — Date thereof: 11 (month) 4 (day) 1946 (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory: Ft. Lincoln Cem.

Location: 3201 Bladensburg Rd. Wash. D.C.

18. Funeral director: S. H. Jones Co.

Address: 2901 - 14th St. N.W. Wash. D.C.

19. Nov. 4 1946 — Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 - 4 1946, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 - 4, 1946, to 11 - 4 1946

and that I last saw him alive on 11 - 4 1946

Immediate cause of death	DURATION
Pulmonary Atelectasis	
Due to: Prematurity.	
Due to: 33 weeks.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: Paul Eaton M.D. — M. D. or other

Address: 4847 - 2nd Ave. — Date signed 11-4-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 11149

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
Homers Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Homers Lane
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Richard Thomas Groom

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Grace M. Groom
6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) June 1 - 1873

8. AGE: Years 73 | Months 5 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Rail Road Laborer
11. Industry or business
FATHER 12. Name Hamilton Groom
13. Birthplace Maryland
MOTHER 14. Maiden name Sally Allen
15. Birthplace Maryland
16. Informant Mrs. Grace M. Groom (wife)
Address Homers Lane - Rockville - Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 27 46 (month) (day) (year)
Cemetery or crematory Forest Oak Cem.
Location Gaithersburg - Maryland
18. Funeral director Wm. Reuben Pumphrey
Address Rockville - Maryland
19. 11/25 1946 Beatrice Snyder Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1946, at 10-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1946, to Nov. 24 1946
and that I last saw h[illegible] alive on Nov. 24 1946

Immediate cause of death	DURATION
Cerebral apoplexy	12 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. N. Hartley M. D.
M. D. or other
Address Rockville, Md. Date signed 11/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

11150

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
4506 Elm St. Chevy Chase, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4506 Elm St. Chevy Chase, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME: MRS. MARGARET BRICHTWELL CUNNINGHAM

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Howard S.
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): January 23, 1887
8. AGE: Years: 59 Months: 10 Days: 0 If less than one day: hrs. min.
9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John W. Brightwell
13. Birthplace: Washington, D. C.
MOTHER 14. Maiden name: Matilda McCormick
15. Birthplace: Washington, D. C.
18. Informant: Mrs. Mary Brightwell Stack
Address: 4506 Elm St. Chevy Chase, Md.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 11/23/46 (month) (day) (year)
Cemetery or crematory: Cedar Hill Crematory
Location: Maryland
18. Funeral director: W. Reuben Thomas & Sons
Address: 7557 Wis. Ave. Bethesda, Md.
19. 11/23 1946 (Date rec'd by registrar) Mrs E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23, 1946 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute myocarditis	4 hrs
Due to: Chronic Calcareous heart disease	2 1/2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brosnahan M.D. Dep. Coroner Exam., M. D. or other
Address: Gaithersburg, Md. Date signed 11-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-154

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

11151

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County: Montgomery

City or town: Tokoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Months

Hospital, institution, or street address where death occurred:
507 Carroll Avenue,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 N. Adams St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: HERBERT SOPER DARBY

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian M.

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Unknown 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73	?	?		

9. Birthplace: Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation: Retired, Clerk-D.C. Police

11. Industry or business:

FATHER — 12. Name: George Darby

13. Birthplace: Montgomery Co., Maryland

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Montgomery Co. Maryland

16. Informant: Mr. George H. Darby

Address: Son, Above address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/29/46 (month) (day) (year)

Cemetery or crematory: Clarksburg Cemetery

Location: Clarksburg, Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. NOV 28 1946 (Date rec'd by registrar) J. Wilbur Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 Nov 1946 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945, to 27 Nov 1946 and that I last saw h[illegible] alive on 26 Nov 1946

Immediate cause of death	DURATION
Cerebral Thrombus	3 wks
Due to Arteriosclerosis	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W S Murphy M.D. M. D. or other

Address: Rockville Md. Date signed: 27 Nov 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46a)

CERTIFICATE OF DEATH

Reg. Dist. No. 2181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Montgomery

City or town Etchison Rural Gaithersburg R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Etchison Rural Gaithersburg R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Steven Boone Darrey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Maude J. Darrey

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Sept 14 - 1871

8. AGE: Years	Months	Days	If less than one day
75	2	9	hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name Humphrey Darrey

FATHER 13. Birthplace Montgy Co Md

MOTHER 14. Maiden name Kate Riggs

MOTHER 15. Birthplace Montgomery Co Md

16. Informant Mrs. Maude J. Darrey

Address Gaithersburg Md R.F.D. # 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26, 1946 (month) (day) (year)

Cemetery or crematory Mt Calvary

Location Howard Co Md

16. Funeral director Roby W. Barber

Address Olney Md

19. 11/25 1946 L.O. Bell

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/46 1946, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 to Nov 19 46

and that I last saw h alive on 19

Immediate cause of death	DURATION
Carcinoma of esophagus	6 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bronhart M.D. M. D. or other

Address Gaithersburg Md Date signed 11-24-46

1-25

2-2180

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

★ 11153

Reg. Diat. No. 3140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: SILVER SPRING.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
IN TAXICAB: ENROUTE TO HIS HOME

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9210 LONG BRANCH PARKWAY
(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3.(a) FULL NAME: LANIER V. DRAKE

3.(b) Social Security Number: 721-12-6704

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: NAOMI A.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): APRIL-27-1914

8. AGE: Years	Months	Days	If less than one day
32.	6	12	..... hrs. ..... min.

9. Birthplace: NORTH CAROLINA.
(Town, county, and state)

10. Usual occupation: PLUMBER

11. Industry or business

FATHER
12. Name: JULIAN C. DRAKE
13. Birthplace: N.C.

MOTHER
14. Maiden name: ETHEL LASSITER
15. Birthplace: N.C.

16. Informant: MRS NAOMI DRAKE
Address: 9210 LONG BRANCH PARKWAY

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: NOV 12-1946 (month) (day) (year)

Cemetery or crematory: ROCK CREEK.

Location: WASHINGTON - D.C.

18. Funeral director: Warner E. Pumphrey

Address: SILVER SPRING - MD

19. NOV-11 (Date rec'd by registrar) 1946 Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/9/ 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from autopsy 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Alcoholism	1 day
Due to: Cerebral Edema	1 day
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Negative except above. Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? ? Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. W. Bird M.D.
M. Dr. or other

Address: Sandy Spring, Md. Date signed: 11/9/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54a)

CERTIFICATE OF DEATH

11154

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46M

1. PLACE OF DEATH:

County: Montgomery

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred: 2 Broxburn Drive, Bethesda 14 D.C.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Broxburn Drive (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Edwin Burchett Earnest

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife: Emily Earnest

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): May 7th 1904

8. AGE: Years	Months	Days	If less than one day
42	6	19	..... hrs. ..... min.

9. Birthplace: Seymour, Iowa U.S.A. (Town, county, and state)

10. Usual occupation: administrative - State Dept.

11. Industry or business:

MOTHER FATHER

12. Name: Chas Edwin Earnest.

13. Birthplace: Ottawa, Ohio.

MOTHER

14. Maiden name: Cora Tennant

15. Birthplace: Virginia

16. Informant: Wife

Address: Broxburn Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof: NOV 29 1946 (month) (day) (year)

Cemetery or crematory: ROCK CREEK

Location: WASHINGTON D-C.

18. Funeral director: Jos. Gawler's Sons

Address: 1756 Penn Ave N.W.

19. 11/27 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 26 1946, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18 1946, to Nov 26 1946 and that I last saw h Him alive on 11 26 1946

Immediate cause of death	DURATION
Coma	6 hrs
Due to: Tumor of the Brain	2½ mo
Due to: Glio-blastoma of corpus callosum. Malig.	
Other conditions: and Duration four months. Q.W.R.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Caryl Burchett M.D. M. D. or other

Address: 1801 Eye St. Date signed: 11.27.46

1-35

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11155

Reg. Dist. No. 216 0

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 min.
Hospital, institution, or street address where death occurred:
Suburban Hosp.
How long in hospital or institution? 5 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 920 Grandin Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Milton I. Embrey

3.(b) Social Security Number: 577-28-7586

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jewell Alcola Embrey
6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): May 30, 1923

8. AGE: Years	Months	Days	If less than one day
23	5	2	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business

FATHER
12. Name: Sumpter M. Embrey, Sr.
13. Birthplace: Bealton, Va.

MOTHER
14. Maiden name: Lucy Earl King
15. Birthplace: Bealton, Va.

16. Informant: Sister- Mrs. Elsie Petty
Address: 4910 Cordell Ave., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/5/46 (month) (day) (year)
Cemetery or crematory: Arlington National Cem.
Location: Arlington, Va.
16. Funeral director: Wm Reuben Humphreys
Address: Bethesda, Maryland

19. 11/4 1946 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 2 19 46 at 1:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage due to shot gun wound in left chest	45 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of 11-2-46
Where did injury occur? Rockville (City or town) Mont. (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: Injured at work?

Frank J. Bosshart M.D.
23. SIGNATURE: Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed 11-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-46M

1-35

11156

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(a)

CERTIFICATE OF DEATH

Reg. Dist. No. 216 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
8 Lone Oak Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Lone Oak Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME SAMUEL TURNER FERGUSON

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jane Thompson Ferguson
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., dy., yr.) April 6, 1868

8. AGE: Years	Months	Days	If less than one day
78	7	19	...hrs. ...min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual occupation Retired- Safeway Stores Co.
11. Industry or business

FATHER
12. Name Perry Ferguson
13. Birthplace South Carolina

MOTHER
14. Maiden name Frances Schooley
15. Birthplace South Carolina

16. Informant Mr. Forrest E. Ferguson
Address 10 Lone Oak Dr. Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/27/46 (month) (day) (year)
Cemetery or crematory Remington Cemetery
Location Remington, Virginia

18. Funeral director Wm Reuben Humphreys
Address 7557 Wisconsin Ave. Bethesda, Md.

19. 11/26 19 46 Wm E Johns Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1946, at 2:45 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to November 25 1946 and that I last saw h.i.m alive on November 24 1946

Immediate cause of death	DURATION
Respiratory Failure	
Due to Coronary Heart Disease	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank G. Joggus M.D.
M. D. or other
Address 8016 Georgetown Rd Date signed 11/26/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

* 11464

Reg. Dist. No. 2230

2

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17½ hrs
Hospital, institution, or street address where death occurred: Wash. Sanit. Hosp. Takoma Park Md
How long in hospital or institution? 17½ hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3201 Idaho Ave. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Fleming, George Edgar.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hadassah L. Fleming
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12, 1867

8. AGE: Years	Months	Days	If less than one day
79	3	25	..... hrs. ..... min.

9. Birthplace West Lebanon, Indiana
(Town, county, and state)
10. Usual occupation Banker (retired)
11. Industry or business —
FATHER 12. Name John S. Fleming
13. Birthplace —
MOTHER 14. Maiden name Frances Adams
15. Birthplace —
16. Informant Sanitarium Records
Address Takoma Park, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8, 1946 (month) (day) (year)
Cemetery or crematory CONGRESSIONAL
Location Md. D. C.
18. Funeral director Jas. Sanders Sons
Address 746 Fa. Ave. N.W.
19. Nov 7 1946 (Date rec'd by registrar) J. Walton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1946, at 5:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27 1936 to Nov 6 1946
and that I last saw h— alive on Nov 5, 1946

	DURATION
Immediate cause of death Chr. Deg. Myocarditis	7 yrs.
Due to Diabetes Mellitus	20 yrs
Due to Coronary Thrombosis	3/13/42
Other conditions Gastric Enteritis	5 days.

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Howard L. Snow M.D.
M. D. or other
28 Carroll Ave Takoma Park Md
Address ..... Date signed 11/6/46

VS-415 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

1M57

Reg. Dist. No. 216-1

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
USNH Bethesda, Maryland

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1725 17th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War ✓

3.(a) FULL NAME: FOLEY, Edward Joseph

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-5-77

8. AGE: Years	Months	Days	If less than one day
69	6	4	hrs. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: (W.P.) Auto Rental Dealer

11. Industry or business:

FATHER
12. Name: Martin Foley
13. Birthplace: Iowa

MOTHER
14. Maiden name: Mary Norton
15. Birthplace: Iowa

16. Informant: Mrs. Marion Buchanan
Address: 25 Elder St., Dorchester, Mass.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 10 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Joseph F. Birch's Sons A.L.H.

Address: 3034 M. St., N.W. Washington, D.C.

19. Nov. 10 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1946, at 2255 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 1946, to November 9 1946

and that I last saw him alive on November 9 1946

Immediate cause of death: Thrombosis coronary artery — DURATION: 10 days

Due to: Coronary artery sclerosis

Due to:

Other conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Permission not granted

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C.W. Thompson
C.W. THOMPSON LT. CMDR. (MC) USNR
M. D. or other

Address: USNH Bethesda, Maryland Date signed: Nov. 9, 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

11/15/46

2-25

2-2160

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

11158

Reg. Dist. No. 2230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery County

City or town: Takoma Park Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 14 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Springs Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8917 Fairview Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Frankeberger Mrs. Eve Q.

3. (b) Social Security Number: 578-32-5663.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Caue	Married

6.(b) Name of husband or wife: John H. Frankeberger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 5 1897

8. AGE:

Years	Months	Days	If less than one day
49	8	6	..... hrs. ..... min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Charles Walter Quantrille

13. Birthplace: Washington D.C.

MOTHER

14. Maiden name: Ellen Wood field

15. Birthplace: Washington, D.C.

16. Informant: Washington Sanitarium & Hospital records

Address: Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 13, 1946 (month) (day) (year)

Cemetery ~~or crematory~~: George Washington Memorial

Location: Riggs Rd., Pr. Geo. Co., Md.

19. Funeral director: Warren E. Humphrey

Address: Silver Spring, Md.

19. Nov 12 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1946, at 7:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1943 to 11-11- 1946

and that I last saw her alive on 11-10 — 1946

Immediate cause of death	DURATION
Respiratory Failure	
Due to: Collapse L. upper lung	2 weeks
Due to: Pleural exit effusion secondary to Ca of L. breast	2 months
Other conditions: Adenocarcinoma left breast (Include pregnancy within 3 months of death)	2 years

Major findings of operations: Adenocarcinoma L. breast

Date of op. Nov. 14 5

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. Thurmond Dodd M. D. or other

Address: Silver Spring, Md. Date signed: 11-11-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9357

CERTIFICATE OF DEATH

Reg. Dist. No. 1115 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, Institution,~~ or street address where death occurred:
332 E Montgomery Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York - County: Kings.
City or town: Brooklyn.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 465 Park Place
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME Wallace Leslie Garrett

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Sarah J.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan - 13 - 1881.

8. AGE: Years	Months	Days	If less than one day
65	9	22	..... hrs. ..... min.

9. Birthplace: Montgomery Co Md
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: U.S. Govt. Employee

FATHER
12. Name: John Wallace Garrett
13. Birthplace: Mont. Co. Md.

MOTHER
14. Maiden name: Mary J Thompson.
15. Birthplace: Mont. Co. Md

16. Informant: Mrs. Lucille Mullinaux
Address: 332 E Montg. Ave Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 9 1946 (month) (day) (year)
Cemetery or ~~crematory~~: Rockville Union -
Location: Rockville - Mont. Co. Md
18. Funeral director: Warner E Humphrey
Address: Silver Spring - Md.

19. 11-13 19 46 (Date rec'd by registrar) Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1946 at 11:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5, 1946 to ..... and that I last saw him alive on Nov. 5 1946

	DURATION
Immediate cause of death: Acute left ventricular failure	½ hour
Due to: Chronic myocarditis	Four years.
Due to: arteriosclerosis	
Other conditions: Peptic ulcer	10 years

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. -
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. A. Linthicum, M.D.
M. D. or other
Address: Rockville, Md. Date signed 11/6/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

526

Reg. Diat. No. 2117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH

County: Montgomery

City or town: Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, Institution, or street address where death occurred: Montgomery County Gen Hosp

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clarence C. Goshorn

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of husband or wife: Rosie Goshorn

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4/12/73 - 1873

8. AGE:

Years	Months	Days	If less than one day
73	7	5	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business

FATHER 12. Name: Elias Goshorn

13. Birthplace: Md

MOTHER 14. Maiden name: Mary Deer

15. Birthplace: Montgomery

16. Informant: Charles Goshorn

Address: Gaithersburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 20 - 1946 (month) (day) (year)

Cemetery or crematory: Laytonsville Md

Location: Montgomery Co Md

18. Funeral director: Roy E. Barber

Address: Laytonsville Md

19. 11-20 1946 (Date rec'd by registrar) Gertrude B Sanders Registrar

MEDICAL CERTIFICATION (150)

20. DATE OF DEATH: 11/17/ 1946, at 2.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/11/ 1946, to 11/17/ 1946

and that I last saw h[illegible] alive on 11/17/ 1946

	DURATION
Immediate cause of death: Uraemia	3 days
Due to: Interstitial Nephritis	2 yrs.
Due to: Carcinoma of Bladder	?
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Bladder

Cystoscopic Exam Date of op. 11/9/46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J W Bird M. D, or other

Address: Sandy Spring, Md Date signed 11/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

1116 1

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 days

Hospital, institution, or street address where death occurred:
USNH Bethesda, Maryland

How long in hospital or institution? 35 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1622 15th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War (S)

3.(a) FULL NAME: HAMM, James Henry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 23 Feb. 1892

8. AGE: Years	Months	Days	If less than one day
54	8	18	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: (VAP) cook

11. Industry or business:

FATHER — 12. Name: William Hamm

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Virgie Monday

15. Birthplace: Virginia

16. Informant: William Hamm

Address: 1622 15th St., N.W. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis J.W.H.

Address: 1432 U. St., N.W. Washington, D.C.

19. Nov. 11 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11 19 46 at 2332 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 7 19 46 to Nov. 11 19 46 and that I last saw h. in alive on November 11 19 46

	DURATION
Immediate cause of death: Coronary heart disease.	3 4 Yrs.
Due to: Arterio Sclerotic.	
Due to: Coronary Thrombosis acute 2 months ago	2 Mo.
Due to:	
Other conditions: C.N.S. Syphilis. -	

(Include pregnancy within 3 months of death)

Major findings of operations: None -

Autopsy results: Coronary heart dis. arterio Sclerotic (advanced) Recent & acute thrombosis 2 mo.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F.E. WETZEL, LT. (MC) USNR. D. or other

Address: USNH Bethesda, Maryland Date signed: 11-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

11/16/46

2-25

2-2160

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9320)

CERTIFICATE OF DEATH

11162

★ Reg. Dist. No. 2160

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 East Leland St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. Thomas R. Harney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Martha G. Harney
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1859

8. AGE: Years	Months	Days	If less than one day
87		21	..... hrs. ..... min.

9. Birthplace Sumter South Carolina
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Thomas Harney
13. Birthplace Ireland

MOTHER 14. Maiden name Kenny
15. Birthplace Ireland

16. Informant Mr. L. P. McLachlen
Address 101 East Leland St. C.C. Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 29 1946 (month) (day) (year)
Cemetery or crematory Cedar Hill Cem.
Location 4000 Maryland Ave N.E.

18. Funeral director Chevy Chase Funeral Home
Address 5103 Wis. Ave N.W.

19. 11/27 1946 (Date rec'd by registrar) Wm E Forbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1946, at 2.40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 1946 to Nov 27 1946 and that I last saw h alive on Nov 26 1946

Immediate cause of death	DURATION
Exhaustion	23 days
Due to Cerebral Thrombosis	6 yrs
Due to Cerebro-sclerosis, Myocardial	
Due to Coronary Occlusion 1939	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Herbert C. Macklyn M.D.
M. D. or other
Address 1332 Mass. Ave NW Date signed Nov 27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-46 M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 11163 2223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. (or R.D.) Carroll Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Maud M. Hendrick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ray L. Hendrick

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): January 23 1877

8. AGE: Years	Months	Days	If less than one day
69	9	15	...hrs. ...min.

9. Birthplace: Hardwick Vermont
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: George W. Hadley
13. Birthplace: Vermont

MOTHER
14. Maiden name: Ellen G. Hockwood
15. Birthplace: Vermont.

16. Informant: Washington Sanitarium & Hosp. Rec.
Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 10, 1946. (month) (day) (year)
Cemetery or crematory: Geo. Wash. Memorial Cemetery
Location: Riggs Road, Hyattsville, Md.

18. Funeral director: Gudgeon Walters.
Address: 354 Carroll Ave. N.W. Takoma Park, D.C.

19. Nov 7 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7th, 1946, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1940, to Nov. 7 1946
and that I last saw h... alive on Nov 7 1946

Immediate cause of death	DURATION
(a) Cerebral arterio sclerosis, general Bad Cerebral with cerebral thrombosis	1 wk
Due to (b) Diabetes Mellitus	yrs ?
Due to (3) Hypertensive heart disease	10-15 yr
Other conditions (4) Senile Hypertension failure and	

(Include pregnancy within 3 months of death)

Major findings of operation: 0 Date of op.:

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

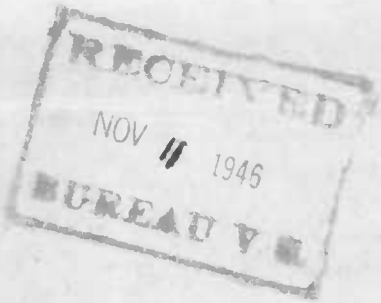
Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas. H. Holden M. D. or other

Address: 500 Edmonds Ave NW Date signed: 11/8/46

SE-1



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

* 11164

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

11/21/46

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 days

Hospital, Institution, or street address where death occurred:
USNH Bethesda, Maryland

How long in hospital or institution? 78 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Prince George Gardens
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I and II

3.(a) FULL NAME: HETFIELD, Francis Ward

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Phola J. Hetfield

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8-22-97

8. AGE: Years	Months	Days	If less than one day
49	2	16	..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Cmdr. (S) USNR

11. Industry or business

FATHER
12. Name: Charles C. Hetfield
13. Birthplace: New York

MOTHER
14. Maiden name: Mary Crawmar
15. Birthplace: Washington, D.C.

16. Informant: Mrs. Phola J. Hetfield
Address: Prince George Gardens, Hyattsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-8-46 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W.W. Chambers Funeral Home

Address: 1400 Chapin St., N.W., Washington, D.C.

19. Nov. 8, 1946 (Date rec'd by registrar) Registrar: Mary Charlotte Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1946 at 0510 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22, 1946 to November 8 1946 and that I last saw him alive on November 8, 1946

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: Following surgical exploration of the rt. kidney	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Congenital anamolies of rt. kidney & liver Date of op. 11/4/46

Autopsy results: Bronchopneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H.J. COKELY CAPT. (MC) USN (M. D. or other)

Address: USNH Bethesda, Maryland Date signed: Nov. 8, 46

2- 25

2- 2160- 1- 10

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (952)

CERTIFICATE OF DEATH

★ 11165

Reg. Dist. No. 7140

1. PLACE OF DEATH:
County Montgomery
City or town Rural - Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 10 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty.
City or town Rural - Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jennie L. Houghton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed.

B.(b) Name of husband or wife —
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 18, 1859

8. AGE:

Years	Months	Days	If less than one day
87	7	17	..... hrs. ..... min.

9. Birthplace Saratoga Springs N.Y.
(Town, county, and state)
10. Usual occupation None
11. Industry or business —

MOTHER FATHER
12. Name — Putnam
13. Birthplace
MOTHER
14. Maiden name —
15. Birthplace —

16. Informant Mrs J. E. Sinclair
Address R.F.D. #1 Silver Spring, Md
17. Burial Date thereof Nov. 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Glenwood Cemetery
Location Washington D.C.
18. Funeral director L. A. Hines Co.
Address 2901-14th St. N.W. Wash. D.C.
19. Nov. 5 1946 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1946, at 12:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1945, to Nov. 4 1946
and that I last saw h— alive on Nov. 4 1946

Immediate cause of death	DURATION
Chronic Myocarditis	—
Due to	
Due to	
Other conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Marion Beechead M.D.
M. D. or other
Address 9601 Sutton pl. Silver Spring, Md. Date signed Nov. 4, 1946

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11166

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 months
Hospital, institution, or street address where death occurred: 615 Greenwood Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 615 Greenwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Russell Israel

3. (b) Social Security Number 013-18-4788 A

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Frances Tenney Israel
Oct 18 1880
6.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 73 Months 1 Days 16 If less than one day ...hrs. ...min.

9. Birthplace Boston, Massachusetts
(Town, county, and state)
10. Usual occupation Salesman
11. Industry or business Printer
FATHER 12. Name John Russell Israel
13. Birthplace Freeport, Nova Scotia
MOTHER 14. Maiden name Charity Ann Lent
15. Birthplace Freeport, Nova Scotia
16. Informant Mrs Frances Tenney Israel
Address 615 Greenwood Ave, Takoma Park, Md.
17. Burial Date thereof Nov. 25-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location So. Lancaster - Mass.
18. Funeral director T. Arthur Pattera
Address 1254 ... Takoma Park
19. Nov. 23 1946 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1946, at 10:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946, to Nov. 23 1946
and that I last saw him alive on 11/23 1946

	DURATION
Immediate cause of death Bronchial pneumonia	3 days
Due to	
Due to	
Other conditions Hypertension, Senility, Old Polio myelitis.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Bruce C. Benjamin M.D. M. D. or other
Address Bethesda 14, Md. Date signed 11/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-m ✓

CERTIFICATE OF DEATH

11167

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Hesketh St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Titian W. Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frank B Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 20, 1876

8. AGE: Years	Months	Days	If less than one day
70			..... hrs. ..... min.

9. Birthplace: Bruce Res Co Ind (Town, county, and state)

10. Usual occupation: Patent Atty.

11. Industry or business

FATHER — 12. Name: William F. Johnson

13. Birthplace: Ind

MOTHER — 14. Maiden name: Mary R. Hanson

15. Birthplace: Ind

16. Informant: Howard Bondy

Address 4836 Bradley Blvd

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Nov 21, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md

18. Funeral director: Deal Funeral Home

Address 4812 Ga. Ave. N.W.

19. Nov 19 1946 (Date rec'd by registrar) Wm E Foley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 November 1946, at 8 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-16- 1946 to 19 Nov 1946 and that I last saw him alive on 19 Nov. 1946

Immediate cause of death	DURATION
Carcinoma gastro-intestinal tract.	2 yrs.
Due to	
Due to	
Other conditions: Hemorrhage, gastrointestinal	1 month
Bronchopneumonia, bilat. terminal (Include pregnancy within 3 months of death)	5 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Stewart Bluff, M.D. M.D. or other

Address 3921 Ingomar St. Wash. D.C. Date signed 19 Nov 46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4-14 — 11168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 819 Heron Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: KARL JOHN KANANEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Elsie Kaneman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8-1906

8. AGE:

Years	Months	Days	If less than one day
40	4	6	hrs. min.

9. Birthplace: Finland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Karl John Kananen
13. Birthplace: Finland

MOTHER
14. Maiden name: Fija Kyrolonen
15. Birthplace: Finland

16. Informant: Mrs. Elsie Kaneman
Address: 819 Heron Drive Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16-1946 (month) (day) (year)

Cemetery or crematory: ~~Hillcrest Cemetery~~ George Park Memorial

Location:

18. Funeral director: J. Arthur Wallace

Address: 254 Carroll Ave Takoma Park

19. Nov-15 1946 (Date rec'd by registrar) Joseph Winkelhoffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14- 1946, at 5: P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1946, to Nov. 14 1946

and that I last saw h...ive on Nov 14, 1946

Immediate cause of death	DURATION
Acute Coronary occlusion	
with myocardial infarction	4 weeks
Due to: Coronary arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Holly Moore M.D.
M. D. or other

Address: 1726 Eye St. N.W. D.C. Date signed: Nov. 14, 1946

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

11163

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 East Irving

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME EMILY TAYLOR KELLOGG

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: EDWARD S. KELLOGG

7. Birth date of deceased (mo., day, yr.): NOV 19 1873

8.(c) If alive, give age ..... years

8. AGE:

Years	Months	Days	If less than one day
72			..... hrs. ..... min.

9. Birthplace: WASHINGTON - D C (Town, county, and state)

10. Usual occupation: AT HOME

11. Industry or business

FATHER — 12. Name: FRANCK E TAYLOR

13. Birthplace: D.C.

MOTHER — 14. Maiden name: ANNA MARY WENDELL

15. Birthplace: D.C.

16. Informant: Edward Stanley Kellogg

Address: #6 East Irving Pl. Ch. Ch.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-12-46 (month) (day) (year)

Cemetery or crematory: Arlington Nat.

Location

18. Funeral director: Jas. Gawler's Sons

Address: 1756 Penn. Ave, Wash D.C.

19. 11/9 1946 (Date rec'd by registrar) Wm E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1946 at 1.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 7th 1938, to Nov 9th 1946

and that I last saw her alive on Nov 9th 1946

Immediate cause of death	DURATION
Uraemia - Cerebral haemorrhage	
Due to: Arteriosclerotic Kidney disease	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. Earl Clark M. D. or other

Address: 1835 Eye Street Date signed 11-9-46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1117

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hrs.

Hospital, Institution, or street address where death occurred:
USNH Bethesda, Md.

How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1211 26th St. Arlington, Va.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: KINGMAN, Matthew Henry USMC Ret. Inact.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Married

6.(b) Name of husband or wife: Mrs. Mildred Kingman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1890

8. AGE: Years	Months	Days	If less than one day
56	8	15	hrs. min.

9. Birthplace: Iowa
(Town, county, and state)

10. Usual occupation: USMC retired

11. Industry or business:

FATHER — 12. Name: Frank Kingman

13. Birthplace: Mass.

MOTHER — 14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Wife: Mrs. M. Kingman

Address: 1211 26th St. Arlington, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-19-46 (month) (day) (year)

Cemetery or crematory: Arlington, National

Location: Arlington Virginia

18. Funeral director: Hines

Address: 2901 14th St., N.W., Wash., D.C.

19. Nov. 16 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 November 1946 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Nov. 1946 to 16 Nov. 1946 and that I last saw h... im alive on 16th. Nov. 1946

Immediate cause of death: Hemorrage Cerebral	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R.C. Parker Jr.
M. D. or other

Address: USNH Bethesda, Maryland Date signed: 11-16-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11/29/46

2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7460

11172

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred:
14 W. Lenox St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 14 W. Lenox St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Maude Irene Kinzer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1884

8. AGE: Years	Months	Days	If less than one day
62	2	21	hrs. min.

8. Birthplace Manhattan, Kansas
(Town, county, and state)
10. Usual occupation Auditor, Dept of Agric.
11. Industry or business U.S. Gov.
FATHER 12. Name George Henry Failyer
13. Birthplace Iowa
MOTHER 14. Maiden name Isabella Blanche Pound
15. Birthplace Black Earth, Wisconsin
16. Informant Corinne Kyle
Address 14 W. Lenox St Chevy Chase, Md
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 11/13/46 (month) (day) (year)
Cemetery or crematory Sunset Cemetery
Location Manhattan, Kansas
18. Funeral director Wm. Reuben Pumphrey
Address Bethesda, Maryland
19. 11/13 1946 Wm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1946 at 6:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1946 to Nov 11 1946
and that I last saw h alive on Nov 10 1946

Immediate cause of death	DURATION
Lymphatic leukaemia	2 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Olive Kogan M.D.
M. D. or other
Address 600 Nevada Ave NW Date signed Nov 11-1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-31-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11173

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH
County Montgomery
City or town Germantown (Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Mo.
Hospital, institution, or street address where death occurred: R.F.D #2 Germantown
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County —
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1841 Columbia Road
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Jeanette D. Kise

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband ~~or wife~~ William E. Kise
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Jan ? 1857

8. AGE:

Years	Months	Days	If less than one day
89	10	?	... hrs. ... min.

9. Birthplace Phila. Pa
(Town, county, and state)
10. Usual occupation Retired U.S. Govt Clerk
11. Industry or business U.S. Gov. Office, D.C.
FATHER 12. Name John Wilson
13. Birthplace Phila. Pa
MOTHER 14. Maiden name Jannet ?
15. Birthplace Pa.
16. Informant Percy Kise
Address 1025 - 10th St N.E.
17. Burial Date thereof Nov. 20 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Congressional Cemetery
Location Washington D.C.
18. Funeral director Zirkle Funeral Home
Address 510 C. St. N.E. Washington
19. 11-19 1946 (Date rec'd by registrar)
per Floyd [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1946, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to Nov. 18 1946
and that I last saw her alive on Nov. 15 1946

	DURATION
Immediate cause of death Acute Myocarditis	5 da
Due to Genl arterial Sclerosis	20 yrs
Due to Chronic Myocarditis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? —
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury Injured at work?

23. SIGNATURE Upton D. Nourse M.D.
M. D. or other
Address Star Route State Dawsonville Md Date signed 11/18/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

1170

Reg. Dist. No. 2281

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 10 Baltimore ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3217 Wis. Ave N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Caroline W. Klein

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband ~~or wife~~: John
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7 1870

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: France (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Michael Weissmuller
13. Birthplace: France

MOTHER
14. Maiden name: Elizabeth Schmidt
15. Birthplace: France

18. Informant: Dr. Charlotte Klein
Address: 3217 Wis. Ave N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-16-46 (month) (day) (year)
Cemetery or crematory: Congressional Cem.
Location: Wash. D.C.
18. Funeral director: J. T. Williams & Sons
Address: 300 - 4½ St. S.E.
19. 11-15 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14 19 46 at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 18 19 45 to Nov. 14 19 46
and that I last saw h-- alive on Nov. 13 19 46

Immediate cause of death	DURATION
Multiple Cerebral Hemorrhage.	23 mos.
Due to: Coronary Sclerosis	6 mos.
Due to:	
Other conditions: Arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓
Date of op.:
Autopsy results: ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of:
Where did injury occur? ✓ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ✓ Injured at work?

23. SIGNATURE: C. H. Lasby M. D. or other
Address: 3800 Cath. Ave. N.W. Washington Date signed 11-14-46

1- 2

2- 2230

1- 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11174

Reg. Dist. No. 2230

1. PLACE OF DEATH

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 7303 Piney Br. Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7303 Piney Branch Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ellen M. Lange

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Sophus —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4/16/1880

8. AGE: Years: 66 | Months: 10 | Days: 12 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Denmark (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Sophus Frantzen

FATHER — 13. Birthplace: Denmark

MOTHER — 14. Maiden name: Lizzie Lange

MOTHER — 15. Birthplace: Denmark

16. Informant: Petrea Hansen

Address: 3713 - 4 - St SE

17. (Burial, cremation, or removal? Which?) Cremation — Date thereof: Nov. 29 1946 (month) (day) (year)

Cemetery or crematory: Lee's Crematorium

Location: 300 - 4. St. N.E

18. Funeral director: Wm Lee's Sons Co

Address: 366 - 4 St. N.E Washington D.C.

19. (Date rec'd by registrar) Nov - 29 1946 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 November 1946, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1946, to 28 Nov 1946.

and that I last saw her alive on 28 Nov. 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hrs.
Due to: Hypertensive Heart Disease.	Several years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G B Cullen M.D. (M. D. or other)

Address: 112 Willow Ave, Takoma Park, Md. Date signed: 29 Nov 46.

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11175

Reg. Dist. No. 2130

1. PLACE OF DEATH:
County Montgomery
City or town Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
212 Maryland Ave. Rockville, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 212 Maryland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME: FRANK D. LEIZEAR

3.(b) Social Security Number: 218-09-4288

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White.	Married

6.(b) Name of husband or wife: ~~Mary~~ Marie Leizear
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): March 24, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	26	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Pres. Mutual Fire Ins. Co.

11. Industry or business

FATHER
12. Name: Francis Thomas Leizear
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary J. Johnson
15. Birthplace: Maryland

16. Informant: Elizabeth R. Leizear (daughter)
Address: 212 Maryland Ave. Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/23/46 (month) (day) (year)
Cemetery or crematory: Woodside Cemetery
Location: Brinklow, Maryland

18. Funeral director: Wm. Reuben Thompson
Address: Rockville, Maryland

19. 11-22-46 (Date rec'd by registrar) Ruth Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20, 1946, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18, 1946, to Nov. 20, 1946, and that I last saw him alive on Nov 19, 1946.

Immediate cause of death	DURATION
Coronary thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. O. Hartley, M.D. M. D. or other
Address: Rockville, Md. Date signed 11/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 11176

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Montgomery Co
City or town: Takoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Takoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7704 Blair Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rina Levine, Mrs (Saul)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	Widow

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1866

8. AGE: 80 Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Max Levine. Russ
13. Birthplace: Russia

MOTHER
14. Maiden name: Edith ??
15. Birthplace: Russia

16. Informant: Mrs Isadore Cohen
Address: 4800 Georgia ave N.W D C

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 13-46 (month) (day) (year)
Cemetery or crematory: Beth Sholom
Location: Capital Hts Md

18. Funeral director: B Danzansky & Son
Address: 3501-14th St

19. Nov. 13 1946 (Date rec'd by registrar) J. William Doyle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 12 1946, at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 31 1946, to Nov 12 1946.
and that I last saw h.. alive on Nov 12 1946.

	DURATION
Immediate cause of death: Bronchopneumonia	5 days.
Due to: Arteriosclerosis and Arterial hypertension	unknown
Due to:	
Other conditions: Right inguinal hernia —	

(Include pregnancy within 3 months of death)

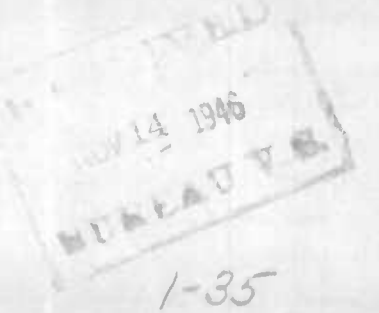
Major findings of operations: Date of op.:

Autopsy results: not permitted

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Herman J. Brown M.D. M. D. or other
Address: 45 Carroll Ave Takoma Park, Md Date signed: Nov 13 '46



1-35

7029 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

★ 11177

Reg. Dist. No. 2160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 4 mos - 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase (If outside city or town limits, write RURAL and give nearest town)
Street No. 28 Kesketh St. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Elizabeth Ann Lewis

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife Seneca D. Lewis 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 17, 1882

8. AGE: Years 64 | Months 2 | Days 17 | If less than one day hrs. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Eugene Mc Fall
13. Birthplace Ohio
14. Maiden name Anna J. Stevens
15. Birthplace Mich -

16. Informant Mr. Robert Cason
Address 28 Hesketh St. Chevy Chase, Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 11/6/46 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Maryland

18. Funeral director W. Reuben Trumpbour
Address Bethesda, Maryland

19. 11/5 1946 (Date rec'd by registrar) Wm E Jobe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 3, 1946, at 11:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1946, to Nov. 3 1946 and that I last saw h alive on Nov. 3 1946

Immediate cause of death	DURATION
Congestive Heart Failure	24 hrs
Due to Cerebro-vascular renal disease with	
Due to Hypertension	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Sidney R Bowerman M.D. M. D. or other
Address 3921 Livingston St. Date signed 11/4/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-0)

CERTIFICATE OF DEATH

★ 11178

Reg. Dist. No. 216 /

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 hours

Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland

How long in hospital or institution? 30hrs. 50min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2853 Ontario Road
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: MANNING Emmett Burr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ruby S. Manning

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 23, 1888

8. AGE: Years	Months	Days	If less than one day
58	9	0	..... hrs. ..... min.

9. Birthplace: Richmond, Virginia
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER — 12. Name: William Joseph Manning

13. Birthplace: Boston, Mass.

MOTHER — 14. Maiden name: Margaret J. Sullivan

15. Birthplace: Richmond, Virginia

16. Informant: Wife: Mrs. Ruby S. Manning

Address: 2853 Ontaro Rd., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-26-46 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: Arlington, Va.

18. Funeral director: Hines Funeral Director LLC

Address: 2901 14 th St. NW Washington

19. 23 Nov. 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 1946 at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 November 1946 to 23 Nov. 1946 and that I last saw him alive on 23 Nov. 1946

Immediate cause of death	DURATION
Myocardial Infarction	48 h
Due to Coronary thrombosis	48 h
Due to Coron. art. sclerosis	years
Other conditions Pulmonary congestion	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. W. Thompson
C. W. THOMPSON
Comdr. (MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-23-46

VS A15 9.45

11/29/46

2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

★ 1117

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1342 Valley Place, S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War ✓

3. (a) FULL NAME: McCRORY, Hugh John, VAP

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 29 June 1898

8. AGE: Years	Months	Days	If less than one day
48	4	29	hrs. min.

8. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER
12. Name: John McCrory
13. Birthplace: Ireland (dec)

MOTHER
14. Maiden name: Mary Cane
15. Birthplace: Ireland (dec)

16. Informant: sister: Mrs. Nellie Deckelman

Address: 1342 Valley Place, S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11-30-46 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington, D. C.

18. Funeral director: Thomas F. Murray S.H.S.

Address: 2007 Nichols Avenue, S.E., Wash., D.C.

19. 11-29 (Date rec'd by registrar) 1946 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 November 1946, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 Nov. 1946, to 28 Nov. 1946 and that I last saw h... im alive on 28 Nov. 1946

Immediate cause of death	DURATION
Hemorrhage, Esophageal vars	5 days
Due to: Cirrhosis, Atrophic, Liver	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. A. Dinsmore Jr.
W. A. DINSMORE, Jr., Lt.Cdr.(MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

12/6/46

2-25

2-2160 — 2-10

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11180

Reg. Dist. No. 223 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

M

I

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred: 903 Flower Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma (If outside city or town limits, write RURAL and give nearest town)

Street No. 903 Flower Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Walter McIntosh

3. (b) Social Security Number:

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Lilly D. McIntosh

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Nov 4 1869

8. AGE:

Years	Months	Days	If less than one day
77	–	4	hrs. min.

9. Birthplace: Va (Town, county, and state)

10. Usual occupation: Supt. American stores

11. Industry or business: grocery

FATHER

12. Name: Robert McIntosh

13. Birthplace: Va

MOTHER

14. Maiden name: Jane Carter

15. Birthplace: Va

16. Informant: ~~Jane~~ Lilly McIntosh

Address: 903 Flower Ave Takoma

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Nov. 12 46 (month) (day) (year)

Cemetery or crematory: Glenwood Cem.

Location: Washington D.C.

18. Funeral director: S H Hines Co

Address: 2901 14th St N.W.

19. Nov 8 1946 (Date rec'd by registrar) J. W. Dudley Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1946, at 3:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam, 19 , to 19

and that I last saw h alive on Case 19

Immediate cause of death: Coronary occlusion

DURATION: died suddenly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed 11-8-46

1-25

2-2230

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

1118 1

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one Month
Hospital, institution, or street address where death occurred:
708 Sligo Ave. Silver Spring, Md.
How long in hospital or institution? one Month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6307 Oakridge Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: MARGARET MICKLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 7th., 1870

8. AGE: Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace: Iowa (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: Joseph Mickle
13. Birthplace: Phil. Pa.

MOTHER
14. Maiden name: Jane Malmsburg
15. Birthplace: Ohio

16. Informant: D. Grant Mickle
Address: 6307-Oakridge Ave. Ch. Ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18, 1946 (month) (day) (year)
Cemetery or crematory: Marshalltown Iowa
Location: Albion, Iowa

18. Funeral director: Chevy Chase Funeral Home
Address: 5103-Wisconsin Ave. N.W. Washington D.C.

19. Nov. 16 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16 1946, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to November 16 1946
and that I last saw h.e alive on November 15 1946

Immediate cause of death	DURATION
Respiratory failure	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank G. Jaggers J. M.D. (M. D. or other)
Address: 8016 Georgetown Rd. Bethesda Date signed: 11/18/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

* 11182

Reg. Dist. No. 316

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town) Maryland

How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington D.C. (If outside city or town limits, write RURAL and give nearest town)

Street No. 3915 Porter St. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: MARIA JACKSIE MIDDLETON

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed.

6.(b) Name of husband or wife: CLARENCE C. MIDDLETON 6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): APRIL 9, 1863

8. AGE: Years	Months	Days	If less than one day
83	8	11	____ hrs. ____ min.

9. Birthplace: THE PLAINS, FAUQUIER, VIRGINIA (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business:

FATHER — 12. Name: JOHN MOFFETT

13. Birthplace: THE PLAINS, VA.

MOTHER — 14. Maiden name: JANE SILCOTT

15. Birthplace: THE PLAINS VA.

16. Informant: MRS. MOFFETT SPILMAN

Address: 2915 - PORTER ST. N.W. WASH. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22 46 (month) (day) (year)

Cemetery or crematory:

Location: Middlebury - Va.

18. Funeral director: S. H. Hines & Co.

Address: Washington D.C.

19. Nov 20 1946 (Date rec'd by registrar) Mrs E. Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 20th 1946, at 2 05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20th 1931 to Nov 20th 1946

and that I last saw h__ alive on Nov 19th 1946

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr
Due to:	
Due to: Bed Immobilization	4 weeks
Other conditions: Fracture of Rt Hip	4 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ Date of

Where did injury occur? Washington D.C. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury fell going from injured at work? bed to toilet - 11 pm. - Oct 12 46

23. SIGNATURE: Truman Abbe M. D. or other

Address: 3741 Huntington St. Date signed: 11/20/46

V S A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11183

Reg. Dist. No. 2161

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3½ days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital

How long in hospital or institution? 3½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 215 8th St., SW
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I (S)

3. (a) FULL NAME: MOCKABEE, Amos Asberry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Margaret Mockabee

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 28, 1890

8. AGE: Years	Months	Days	If less than one day
56	7	25	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: Henry C. Mockabee
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Sarah Lanseby
15. Birthplace: unknown

16. Informant: Sister: Mrs. Laura V. Ellis

Address: 73 Bates St. NW Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-26-46 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers M.R.

Address: 1400 Chapin St. NW

19. 11-23 (Date rec'd by registrar) 1946 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 November 1946, at 5:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Nov. 1946, to 23 Nov. 1946 and that I last saw him alive on 23 Nov. 1946

	DURATION
Immediate cause of death: uremia	days
Due to: Chronic glomerulonephritis.	
Due to:	
Other conditions: hypertensive heart disease	years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson
C. W. THOMPSON
Comdr. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-23-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45 15M

11/29/46

2-21

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

54b 11184

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos. 1 day
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Md.
How long in hospital or institution? 3 mos. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penn. County:
City or town: Halifax
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war: (S) World War II

3. (a) FULL NAME: MUSSER, Charles Junior

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Pauline Musser
6.(c) If alive, give age: —— years

7. Birth date of deceased (mo., day, yr.): March 16, 1925

8. AGE: Years	Months	Days	If less than one day
21	8	12	hrs. min.

8. Birthplace: Penn.
(Town, county, and state)
10. Usual occupation: unknown
11. Industry or business:
FATHER 12. Name: Charles Musser
FATHER 13. Birthplace: Penn.
MOTHER 14. Maiden name: Sally Miller
MOTHER 15. Birthplace: Penn.
16. Informant: Mrs. C. J. Musser
Address: Rd #1 Halifax, Penn.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-28-46 (month) (day) (year)
Cemetery or crematory: cemetery
Location: Millersburg, Penn.
18. Funeral director: W. W. Chambers RWB.
Address: 1400 Chapin Street NW Wash, D.C.
19. 11-28- 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 November 1946, at 0700 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Aug. 1946, to 28 Nov. 1946, and that I last saw him alive on 28 Nov. 1946.

	DURATION
Immediate cause of death: Brain Tumor	
Brain Tumor	6 Mos.
Due to: Respiratory Failure	6 hrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Malignant Brain Tumor Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. N. Weaver E. N. Weaver Lt.(jg) MC USNR M. D. or other
Address: USNH Bethesda, Md. Date signed: 11-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

12/7/46

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (925)

CERTIFICATE OF DEATH

(★) 1118

Reg. Dist. No. 2161

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours 5 min.

Hospital, institution, or street address where death occurred:
USNH Bethesda, Maryland

How long in hospital or institution? 6 hours 5 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 705 17th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I (S) ✓

3. (a) FULL NAME: NASH, Thomas Jefferson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband or~~ wife: Maude Groome

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): 8-20-86

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
60	3	1		

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: General accountant

11. Industry or business: Civil Service

FATHER
12. Name: Thomas Jefferson Nash

13. Birthplace: Virginia

MOTHER
14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Son: Thomas J. Nash

Address: 705 17th St., N.W.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 25, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W.W. Chambers J.E. Boone

Address: 1400 Chapin St., N.W. Wash., D.C.

19. Nov. 21 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1946, at 2:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 21 (1000) 1946, to Nov. 21 1946, and that I last saw him alive on November 21, 1946

Immediate cause of death	DURATION
Myocardial infarction	12 hours
Due to: Cor. art. Scler.	
Due to:	
Due to:	
Other conditions: Pulmonary fibrosis, aortic stenosis.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C.W. Thompson C.W. THOMPSON LT. CMDR. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: Nov. 21, 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

11/29/46

2 - 25

2-2160-2-10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

11186

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 11-15-46 (10 P.M.)
Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd Bethesda Md.
How long in hospital or institution? Since 11-15-46-10 P.M.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County
City or town Chevy Chase (If outside city or town limits, write RURAL and give nearest town)
Street No. 101 E Underwood (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs Lulu H. O'Shea

3. (b) Social Security Number

4. Sex: F
5. Color or race: W
6. (a) ~~Single, married~~, widowed, ~~or divorced~~
6.(b) Name of husband ~~or wife~~ John O'Shea
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) October 4, 1873

8. AGE:

Years	Months	Days	If less than one day
73	1	13	... hrs. ... min.

9. Birthplace San Francisco, California (Town, county, and state)
10. Usual occupation Household duties
11. Industry or business

FATHER
12. Name William Holcomb
13. Birthplace N. Hero Island, Vermont

MOTHER
14. Maiden name Louisa Carr
15. Birthplace Lexington, Kentucky

16. Informant Hosp. records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20-46 (month) (day) (year)
Cemetery or crematory Arlington Nat Cem
Location " Va
18. Funeral director The S.H. Hines Co.
Address 2901-14 St. N.W. Wash. D.C.
19. 11/17 1946 (Date rec'd by registrar) Wm E Jubec Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1946 at 7:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1946, to Nov 17 1946 and that I last saw h~~im~~ er alive on Nov. 16 1946

	DURATION
Immediate cause of death Acute Cardiac failure	24 hrs
Due to Cardio-vascular renal disease with	
Due to Hypertension	3 yrs
Other conditions	

(Include pregnancy within 3 months of death.)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Sidney L. Caraman [illegible] M. D. or other
Address 3921 Ingomar St. N.W. Date signed 11/17/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-a)

CERTIFICATE OF DEATH

★ 11187

Reg. Diat. No. 2180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montg Co,

City or town: Germantown, Rural, Senica M

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10hrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D C, County:

City or town: Washington D C,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2817-28th St, N W,

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Thomas Edward Parrish Jr,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Comora A Parrish

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 8th 1895

8. AGE: Years	Months	Days	If less than one day
1895 51	8	22	hrs. min.

9. Birthplace: Lynchburg. Va, (Town, county, and state)

10. Usual occupation: Painter & Decorator

11. Industry or business: " "

FATHER — 12. Name: Thomas E Parrish

13. Birthplace: Va,

MOTHER — 14. Maiden name: Margarett Dudley

15. Birthplace: Va,

16. Informant: Comora A Parrish

Address: 2817 -28th St N W, Washington

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/2/46 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: 3201 Bladensburg Rd, Washington D C

18. Funeral director: The H.S.KINES Co,

Address: 2901 -14th St N W, Washington.D C.

19. N D 30 1946 (Date rec'd by registrar) Abraded G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 30th 1946, at 5:40 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Cardiac dilatation	2 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M. D. Dep Med Exam M. D. or other

Address: Gaithersburg Md Date signed 11-30-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

11188

Reg. Diat. No. 2230

1. PLACE OF DEATH:

County Montgomery

City or town Takoma PK md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 6 1/2 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma PK. Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1106 Flower Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Patterson, Mrs Zella Jane

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Mr. Oliver Patterson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 11- 1876

8. AGE: Years	Months	Days	If less than one day
69	11	29	..... hrs. ..... min.

9. Birthplace Akron, Ohio
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business own home

FATHER 12. Name JOHN STRAYER

13. Birthplace —

MOTHER 14. Maiden name MARTHA

15. Birthplace —

16. Informant Washington San. & Hosp. Records

Address Takoma PK md.

17. Burial — Date thereof Nov. 16, 1946.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Liberty Hash Memorial Cemetery

Location Rte 1 & Prince Geo Co. Hyattsville Md.

18. Funeral director Arthur Fallon.

Address 254 Carroll St. N.W. Takoma Park, D.C.

19. NOV. 10 1946 J. Milton Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1946, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946, to 11-9 1946.

and that I last saw h.e.r alive on 11-9 1946.

	DURATION
Immediate cause of death: Acute Cardiac Dilatation	
Due to: Chronic Bronchial Asthma	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lean V. Harding M.D. M. D. or other

Address 113 Carroll St. N.W. Washington 12, D.C. Date signed 11-9-46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11189

Reg. Dist. No. 2150

1. PLACE OF DEATH:
County: Montgomery
City or town: Avery Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: R-7-D Rockville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Avery Road
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R 7 D Rockville
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Wm Paul Pratt

3.(b) Social Security Number: 214-03-8384

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara S. Pratt
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): September 24-1906

8. AGE: Years: 40 | Months: 1 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business:

FATHER
12. Name: Martin L. Pratt
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary G. Sweat
15. Birthplace: North Carolina

16. Informant: Mrs Clara S. Pratt (wife)
Address: R 7 D Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov-17/46 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Maryland
18. Funeral director: Wm. Roubal Funeral Home
Address: Rockville Maryland

19. Nov 16 1946 (Date rec'd by registrar) Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15 1946 at 10.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1946 to Nov 15 1946 and that I last saw him alive on Nov 15. 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs.
Due to	
Due to	
Other conditions Hodgkins disease?	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C E Hawks M. D.
M. D. or other
Address: Rockville Md Date signed: 11/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

11190

CERTIFICATE OF DEATH

Reg. Dist. No. 2130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Rockville, md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Laura Shaw

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1878

8. AGE: Years 68 | Months | Days | If less than one day hrs. min.

9. Birthplace Rockville, md.
(Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business

FATHER 12. Name Dennis Smith
13. Birthplace md

MOTHER 14. Maiden name Catherine Rozier
15. Birthplace md

16. Informant Mrs Jessie Meads
Address Rockville, md

17. Burial (Burial, cremation, or removal, which?) Date thereof Nov 26 1946 (month) (day) (year)
Cemetery or crematory Lincoln Park
Location Rockville, md.

16. Funeral director Robert L. Snowden
Address Rockville, md.

19. 11-26 1946 (Date rec'd by registrar) Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24th 1946, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22nd 1946, to Dec 24th 1946, and that I last saw h alive on Dec 24th 1946

Immediate cause of death	DURATION
Acute Myocarditis	1 hr.
Due to Chronic Valvular heart disease	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. J. Bouchart M.D.
Dep. Med. Exam.
M. D. or other
Address Gaithersburg md Date signed 11-26-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 1a

11191

Reg. Dist. No. 2170

1. PLACE OF DEATH:
County Montgomery
City or town Norbeck
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Norbeck
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Arthur Ricks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	AA	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1881

8. AGE: Years	Months	Days	If less than one day
65	8	1	hrs. min.

9. Birthplace Norbeck, Maryland (Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business

FATHER
12. Name Monroe Ricks
13. Birthplace Alabama.

MOTHER
14. Maiden name Amanda Massey.
15. Birthplace Maryland.

16. Informant Zephaniah Ricks (Bro).
Address Norbeck, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 27 1946 (month) (day) (year)
Cemetery or crematory Norbeck
Location Norbeck, Md.
18. Funeral director Robert L. Snowden
Address Rockville, Md.

19. 11-27-1946 (Date rec'd by registrar) Leonard B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1946, at 5:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1946, to November 24 1946 and that I last saw h.. alive on November 21 1946

Immediate cause of death	DURATION
Coronary Thromboses or Rupture with a Stroke	
Due to Hypertensive Cardio Renal Disease C	
Due to	
Other conditions Edema	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Webster Sewell M.D.
M. D. or other
Address Norbeck Date signed Nov 26 '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11192 2160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46

1. PLACE OF DEATH:
County MONTGOMERY
City or town BROOKMONT
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County MONTGOMERY.
City or town BROOK MONT
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6512 - RIDGE DRIVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME SAMUEL RIGGS.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED.

6.(b) Name of husband or wife MARTHA. ELLEN RIGGS.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH. 26 - 1869.

8. AGE: Years 77 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace ST. MARYS - WEST - VA.
(Town, county, and state)

10. Usual occupation CARPENTER.

11. Industry or business

FATHER 12. Name JACKSON RIGGS.
13. Birthplace ?

MOTHER 14. Maiden name JEANETTE ISRAEL.
15. Birthplace ?

16. Informant MRS - GEO. R. LEE.
Address 6512 - RIDGE DRIVE

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11, 1946 (month) (day) (year)
Cemetery or crematory Cedar Hill Cem
Location Md

18. Funeral director W. W. Chambers Co.
Address 3072 - M - ST - N.W.

19. 11/9 1946 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1946 at 12 25 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 25, 1946, to Nov. 8, 1946
and that I last saw him alive on Nov. 8, 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	14 days
Due to Arteriosclerosis	
Due to	
Other conditions Cardiac hypertrophy and Hypertension.	10+ years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. Stephen Hulbert, M.D. M. D. or other
Address 3000 Dent Pl. N.W. Date signed Nov. 8, 1946

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

11193

Reg. Dist. No. 216/

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
USNH Bethesda, Maryland

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1124 S. St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: SCOTT, Lucion (n)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	single

6.(b) Name of husband or wife: Mrs. Mabel Scott

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-3-92

8. AGE: Years	Months	Days	If less than one day
54	- - - -	3	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: (Veteran) Laborer for D.C. Gov.

11. Industry or business:

FATHER
12. Name: Scott
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Johnson
15. Birthplace: Virginia

16. Informant: Mrs. Mabel Scott

Address: 1124 S. St. N.W. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 7, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Ernest W. Jarvis

Address: 1432 U. St., N.W. Washington, D.C.

19. Nov. 6, 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 1946, at 1920 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28 1946, to November 6 1946

and that I last saw him alive on November 6, 1946

Immediate cause of death: Thrombosis coronary artery & myocardial infarction — DURATION: 1 week

Due to: Coronary artery sclerosis. — DURATION: years

Due to:

Other conditions: Arteriosclerosis st. Louis lobe. Bronchopneumonia
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

C W Thompson

23. SIGNATURE: C.W. THOMPSON LT.CMDR.(MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: Nov. 6, 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15 9.45

(11/13/46)

2-25

2-2160

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

2

11194

Reg. Diat. No. 2160

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town) Maryland

How long in above place of death? Since Oct. 30, 1946

Hospital, Institution, or street address where death occurred: Suburban Hosp. - 8600 Old Georgetown Rd. Bethesda, Md.,

How long in hospital or institution? Since Oct. 30, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington (If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Warfield St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Mary C Selby

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife Arthur C. Selby (Dec.)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1872

8. AGE: Years	Months	Days	If less than one day
74	0	23	..... hrs. ..... min.

9. Birthplace Rockville Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Butt

13. Birthplace Potomac, Maryland

MOTHER 14. Maiden name Matilda Offutt

15. Birthplace Potomac, Maryland

16. Informant E. Leonard Daymude

Address 15 Howard Ave., Kensington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/3/46 (month) (day) (year)

Cemetery or crematory Rockville Union Cem.

Location Rockville, Md.

18. Funeral director Wm Reuben Humphrey

Address Bethesda, Md.

19. 11/2 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1946, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/7/46 19.., to 11/1/46 1946 and that I last saw h.r alive on 11/1/46 1946

Immediate cause of death	DURATION
(a) Cardiac Decompensation	approx. month
Due to (b) Pulmonary Edema & Peripheral Edema	
Due to (c) Myocardial Degeneration & marked Hypertrophy, probably	
Due to (d) Rheumatic Brain	undetermined
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Leonard Miller M. D. or other

Address Kensington, Md. Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

11195

Reg. Dist. No. 7140

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 509 Schuyler Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lillian C. Severin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William P. Severin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 25

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: N. Y. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Lovey Paine
13. Birthplace: N.Y.
MOTHER 14. Maiden name: Anna J. Hendry
15. Birthplace: N. Y.
16. Informant: Dorothy J. Paine
Address: 1312 Emerson St NW
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 13 1946 (month) (day) (year)
Cemetery or crematory: Arlington Nat
Location: Arlington Va
16. Funeral director: Deal Funeral Home
Address: 4812 Ga Ave. NW
19. Nov 9 1946 (Date rec'd by registrar) Josephine M. Shaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9, 1946 at 1 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-9- 1946, to 11-9- 1946, and that I last saw h alive on 11-8- 1946

Immediate cause of death	DURATION
Congestive heart failure	10 days
Due to: Cardio-vascular disease	10 years
Due to: generalized arteriosclerosis	10 years
Other conditions: Cerebral thrombosis	2 weeks
Broncho-pneumonia	4 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. E. Shoemaker M.D. M. D. or other
Address: 8005 Woodbury Drive Silver Spring, Md Date signed: 11/9/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

11196

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH

County: Montgomery Co.

City or town: Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:
8204 Colston Pl.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8204 Colston Pl.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MRS SHERBERT, ANNABELLE SMALLWOOD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: THOMAS LEROY SHERBERT

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.): July 6, 1906

8. AGE: Years 40 | Months 4 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: William W. Smallwood
13. Birthplace: Fauquier Co., Va.

MOTHER
14. Maiden name: Lula Ballard
15. Birthplace: Marshall Va

16. Informant: Mrs. John J. Dolan
Address: 1439 Highland Drive, Silver Spring, Md.

17. Burial: Date thereof 11/19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Washington National Cemetery
Location: Md.

18. Funeral director: The S.H. Kauffman Co.
Address: 2901 14th St. Washington, D.C.

19. Nov 16 1946 Wm E Jolley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 1946, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1924, to Nov 16 1946, and that I last saw h[illegible] alive on Nov 15 1946.

	DURATION
Immediate cause of death: Hemangioendothelioma	1½ yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. W. Mitchell M.D.
M. D., or other

Address: Silver Spring, Md. Date signed 11-16-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

★ 11197

Reg. Diat. No. 216 /

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
U.S. NAVAL HOSPITAL Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 529 Oglethorpe St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st. World War (S) ✓

3. (a) FULL NAME: SMART, JOSEPH, BERNARD VAP

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	w	Married

6.(b) Name of husband or wife: Helen Smart

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October, 20, 1894

8. AGE: Years	Months	Days	If less than one day
52	0	14	..... hrs. ..... min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: Richard Smart
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget O'Brien
15. Birthplace: Ireland

16. Informant: Wife: Helen Smart
Address: 529 Oglethorpe St. NW Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. (month) 5 (day) 1946 (year)

Cemetery or crematory: Arlington National
Location: Arlington Virginia

18. Funeral director: Jos. Gawler Sons
Joseph Gawler & Sons
Address: 1756 Pa. Ave NW.

19. 3 Nov. 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 November 1946, 8:05 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 30 October 1946, to 3 Nov. 1946 and that I last saw him alive on 3 Nov 1946

	DURATION
Immediate cause of death: Congestive heart failure	1 wk
Due to: myocardial infarct	1 wk
Due to: arteriosclerosis	years
Other conditions: Diabetes mellitus and clinically a cerebral vascular accident. (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....

Autopsy results: no permit for head. Rest substantiated

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles W Thompson
C. W. THOMPSON Lt. Comdr (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed .....

(45146)

1-25

2-2160

1-10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

11198

CERTIFICATE OF DEATH

Reg. Dist. No. 2180

1. PLACE OF DEATH:
County: Montgomery
City or town: Germantown (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Germantown (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Jane Ann Snyder

3. (b) Social Security Number

4. Sex: F.
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: ~~[illegible]~~
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Nov. 17-1934

8. AGE: Years 12 Months 0 Days 6 If less than one day ... hrs. ... min.

9. Birthplace: Washington DC.
(Town, county, and state)
10. Usual occupation: School girl
11. Industry or business

FATHER
12. Name: Ross H. Snyder
13. Birthplace: Germantown Md (Rural)

MOTHER
14. Maiden name: Jennie Snyder
15. Birthplace: Germantown Md (Rural)

16. Informant: Henry H. Russell
Address: Arlington, Va.

17. Burial — Date thereof: 11-27-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington, D.C.

18. Funeral director: S. H. Hines Co.
Address: Washington, D.C.

19 Nov 24 1946 Almeda G. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1946, at 1:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep. Med. Exam. 19 ... case ... 19
and that I last saw h... alive on ... 19

Immediate cause of death: Hemorrhage
Due to: Gun shot wound in skull
Due to: Homicide

DURATION: killed instantly

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: 11-23-46
Where did injury occur? Germantown R-2 (City or town) Montg. (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Gun shot Injured at work? no

23. SIGNATURE: [illegible] J. Broschart M.D. Dep. Med. Exam.
M. D. or other
Address: Gaithersburg Md Date signed 11-23-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

CERTIFICATE OF DEATH

11199

Reg. Dist. No. 2180

1. PLACE OF DEATH:

County: Montgomery

City or town: Germantown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Germantown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Jennie Russell Snyder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(c) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Rosa H. Snyder

6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.): June 28, 1898

8. AGE: Years	Months	Days	If less than one day
48	4	25	hrs. min.

9. Birthplace: Washington, DC.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: David W. Russell

13. Birthplace: Canada

MOTHER — 14. Maiden name: Maude Mann

15. Birthplace: Washington, DC.

16. Informant: Henry H. Russell

Address: 1220 Lime One - Arlington, Va.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 11-27-46 (month) (day) (year)

Cemetery or crematory: Arlington Natl. Cemetery

Location: Arlington, Va.

18. Funeral director: S. H. Kline Co.

Address: Washington, D.C.

19. NOV 24 1946 (Date rec'd by registrar) Abeda E. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1946 at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec Med Exam 1946 to — 1946

and that I last saw h alive on — 1946

Immediate cause of death	DURATION
Gun shot wound thru skull	Instantly
Due to: Homicide	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 11-23-46

Where did injury occur? Germantown R-2 (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: gun shot Injured at work? no

23. SIGNATURE: Frank J. Brochart M.D. M. D. or other

Address: Gaithersburg Md Date signed 11-23-46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (146)

CERTIFICATE OF DEATH

112111

Reg. Diat. No. 2180

1. PLACE OF DEATH:

County: Montgomery

City or town: Germantown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Germantown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. (9)

(If rural, give LOCATION)

2.(a) If veteran, name war: World War #1

3. (a) FULL NAME: Ross H. Snyder

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband or~~ wife: Jennie W. Snyder

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov. 30, 1897

8. AGE:

Years	Months	Days	If less than one day
49	11	24	..... hrs. ..... min.

9. Birthplace: Coffeen, Ill.

(Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business: —

FATHER

12. Name: William H. Snyder

13. Birthplace: Ill.

MOTHER

14. Maiden name: Elizabeth Whitford

15. Birthplace: Ill.

16. Informant: Mrs. Jean C. Snyder

Address: Hillsboro, Ill.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-27-46 (month) (day) (year)

Cemetery or crematory: Arlington Nat'l. Cemetery

Location: Arlington, Va.

16. Funeral director: S. H. Hines Co.

Address: Washington, D.C.

19. Nov. 24 1946 (Date rec'd by registrar) Alvada G. Locke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1946 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. med. Exam 19.. to .. 19.. and that I last saw h.. alive on .. 19.. this case

Immediate cause of death	DURATION
Gun shot wound Thru Skull	Instantly
Due to: Homicide	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 11-23-46

Where did injury occur? Germantown R-2 (City or town) Mont'y (County) Md (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: Gun shot Injured at work? no

23. SIGNATURE: Frank J. Broshart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg, Md. Date signed 11-23-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11201

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Westgate, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:
4906½ Westway Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Westgate, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4906½ Westway drive.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: JAMES ABRAHAM SORRELL

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Virginia Allen

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 8, 1880

8. AGE: Years	Months	Days	If less than one day
66	8	26	hrs. min.

9. Birthplace: Richmond, Virginia
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER — 12. Name: James Park Sorrell

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Annie Burns

MOTHER — 15. Birthplace: Virginia

16. Informant: James E. Sorrell, Son

Address: Same as above

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/8/46 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Bethesda, Maryland

18. Funeral director:

Address: Bethesda, Maryland

19. 11/5 (Date rec'd by registrar) 19 46 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4, 1946, at 11:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19 to 19

and that I last saw him alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Sept. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed 11-5-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 546

CERTIFICATE OF DEATH

11202

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: S. C. County:

City or town: Ft. Mill
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 457
(If rural, give LOCATION)

2.(a) If veteran, name war: Marine Corps

3.(a) FULL NAME: TALLEY, Charles Clifford, Sgt. USMC

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 22 May 1922

8. AGE: Years	Months	Days	If less than one day
24	6	6	hrs. min.

9. Birthplace: S.C.
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business:

FATHER
12. Name: J. L. Talley
13. Birthplace: N. C. dec.

MOTHER
14. Maiden name: Margaret Blankenship
15. Birthplace: S.C.

16. Informant: Mo: Mrs. Margaret C. Talley
Address: Box 457, Ft. Mill, S. C.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 11-29-46 (month) (day) (year)

Cemetery or crematory:

Location: Rock Hill, S. C.

18. Funeral director: W. W. CHAMBERS E.J.

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 11-29 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 Nov. 19 46 at 10:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Nov. 19 46 to 28 Nov. 19 46 and that I last saw h im alive on 28 Nov. 19 46

Immediate cause of death	OURATION
Basilar Meningitis	2 days
Due to Scalp infection	2 wks
Due to Brain Tumor - Craniotomy done	6 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Frontal lobe brain tumor Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. N. Weaver
E. N. WEAVER, Lt.(jg) (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45

12/6/46

2-25

2-2160 —— 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★11203

Reg. Dist. No. 2180

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg . Md,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Mo

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montg

City or town: Gaithersburg Md,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Miss Clara Ruth Thompson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 17th 1861

8. AGE: Years	Months	Days	If less than one day
1861 85	5	11	..... hrs. ..... min.

9. Birthplace: Montg Co, Md,
(Town, county, and state)

10. Usual occupation: House Companion

11. Industry or business: " "

FATHER
12. Name: Albert Thompson
13. Birthplace: Md,

MOTHER
14. Maiden name: Sallie Bowman
15. Birthplace: Md,

16. Informant: Mrs G Gordon Bailey
Address: 1415 Hamilton St, N W,
Washington D C,

17. (Burial, cremation, or removal. Which?) Buried Date thereof 12/1/46 (month) (day) (year)

Cemetery or crematory: Baptist Church Cemetery

Location: Cedar Grove Md,

18. Funeral director: Ernest C. Gartner

Address: Gaithersburg Md,

19. Nov 30 1946 (Date rec'd by registrar) Rhoda L. Drake Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28th 1946 at 6 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9 1946 to Nov. 28 1946

and that I last saw her alive on Nov. 28 1946

Immediate cause of death	DURATION
Chronic myocarditis & myocardial degeneration	6 yrs.
Due to: Arteriosclerosis	more than 20 yrs.
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. Selby, M.D. M. D. or other

Address: Dawsonville, Md. Date signed 29 Nov. 46

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

11204

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 10 Grafton St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SOUTH TRIMBLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: Carrie Belle Allan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 13 - 1864

8. AGE:

Years	Months	Days	If less than one day
82			..... hrs. ..... min.

9. Birthplace: Wolfe Co. Ky.

(Town, county, and state)

10. Usual occupation: Government Official

11. Industry or business

FATHER

12. Name: ASBURY TRIMBLE

13. Birthplace: KY

MOTHER

14. Maiden name: MARY ELIZABETH SOUTH

15. Birthplace: Ky

16. Informant: Mrs Eunice Wallace

Address: 10 Grafton ch. ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 24 46 (month) (day) (year)

Cemetery or crematory:

Location: Frankfort, Ky.

18. Funeral director: Jas Gawler & Sons

Address: 1756 Penn ave. wash. D.C.

19. 11/23 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23rd 1946 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16th 1946 to Nov 23rd 1946 and that I last saw h. alive on Nov. 22nd 1946

Immediate cause of death	DURATION
Myocardiac failure	1/2 hour
Due to: Bronchopneumonia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. B. Lewis M. D. or other

Address: 1746 K St NW Date signed 11/23/46

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11205

Reg. Dist. No. 2110

1. PLACE OF DEATH:
County: Montgomery
City or town: Damascus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
R. F. D. Monrovia
How long in hospital or institution? At home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Damascus
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MINNIE AMANDA WATKINS

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles Lee Watkins, Sr deceased Jan. 1937
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 17, 1870

8. AGE: Years	Months	Days	If less than one day
76	8	19	..... hrs. ..... min.

9. Birthplace: Near Kings Valley, Montg. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: Edward King
13. Birthplace: Kings Valley, Montg. Co. Md

MOTHER
14. Maiden name: Jane Burdette
15. Birthplace: Montgomery Co., Maryland

16. Informant: Talmadge Watkins
Address: Germantown, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8, 1946 (mouth) (day) (year)
Cemetery or crematory: Baptist Church Cemetery
Location: Cedar Grove, Maryland.

18. Funeral director: J. B. Beall Inc.
Address: Damascus, Maryland.

19. Nov 8 1946 (Date rec'd by registrar) Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1946, at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1935 to Nov 1946 and that I last saw her alive on November 5, 1946

Immediate cause of death	DURATION
Generalized Arteriosclerosis	10 yrs.
Hypertension - moderate	15 yrs.
Due to: Multiple Cerebral Thromboses since Feb. '46	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. McKendree Boyer M.D.
Address: Damascus, Maryland. M.D. or other
Date signed 11-7-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore /23

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Woodbridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: WHITCRAFT, Norris (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1887

8. AGE:	Years	Months	Days	If less than one day
	59	6	5	hrs. min.

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: VAP

11. Industry or business:

FATHER
12. Name: Edgar Whitcraft
13. Birthplace: Ohio

MOTHER
14. Maiden name: Elizabeth Propeck
15. Birthplace: Ohio

16. Informant: Miss Ruth Whitcraft
Address: Woodbridge, Virginia

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 13, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Hall Funeral Home F. L. Brown

Address: Occoquan, Virginia

19. Nov. 12, 19 46 (Date rec'd by registrar) M.C. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 November 1946, at Bethesda, M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 November 1946, to 10 November 1946 and that I last saw h... alive on 10 November 1946

Immediate cause of death	DURATION
Acute Pulmonary Edema,	
Due to Cardiac Failure	
Due to Massive Gastro-Intestinal Hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. R. Coope Lt.(MC) USN
M. D. or other

Address: USNH Bethesda, Maryland Date signed: Nov. 12, 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

11/15/46

1-25

S. 2160

4-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

112-17-2480

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Montg Co.

City or town: Darnstown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montg

City or town: Darnstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Arthur James Wilkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mollie E Wilkins

6.(c) If alive, give age: 60. years

7. Birth date of deceased (mo., day, yr.): April 3rd 1885

8. AGE: Years	Months	Days	If less than one day
1885 61	7	6	hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Carpenter
11

11. Industry or business

FATHER — 12. Name: Henry Wilkins
13. Birthplace: W.Va,

MOTHER — 14. Maiden name: Susan Snyder
15. Birthplace: W. Va,

18. Informant: Mrs Mollie E. Wilkins
Address: Darnstown, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/12/46 (month) (day) (year)

Cemetery or crematory: Darnstown Cemetery

Location: Darnstown. Md,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg. Md,

19. Nov. 11 1946 (Date rec'd by registrar) Abuda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9th 1946 at 11.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept - 28 - 1946, to Nov - 9 - 1946 and that I last saw h... alive on Nov - 9 - 1946

Immediate cause of death	DURATION
Cardio - nephritis	1 mo. 11 days
Due to Carcinoma of Stomach	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. C. Miller M.D. M. D. or other

Address: Gaithersburg Md Date signed 11/11/46

1-35

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-46 5M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 46 - W. Lenox St. Ch. Ch. Md.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Chevy Chase. (If outside city or town limits, write RURAL and give town)
(d) Street No. 46 Lenox St. (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Sadie M. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 11

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Married.

6 (b) Name of husband ~~or wife~~ Moses Williams
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 1902

8. AGE: Years	Months	Days	If less than one day
44			..... hr. ..... min.

9. Birthplace ..... (Town, county, and state)
10. Usual Occupation Maid
11. Industry or business

FATHER
12. Name James Haden
13. Birthplace Va.

MOTHER
14. Maiden Name Paulina Scott.
15. Birthplace Va.

16 (a) Informant Charles L. Williams
(b) Address 1700 - 2nd St. N.W. Wash. D.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-28-46 (month) (day) (year)
(c) Cemetery or crematory .....
Location Washington, D.C.

18 (a) Funeral director W. Earnest Jarvis Co.
(b) Address 1472 - Park Rd. N.W. Wash. D.C.

19 (a) 11-28-46 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased ~~from~~ on Nov. 27th 19 1946 19 ....., and that I last saw h~~e~~r alive on 11-27 19 46.

Immediate cause of death	Duration
Coronary occlusion	30 min.
Due to Hypertension + arterio-sclerotic heart disease	10+ min.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature K. R. Mervin, M.D.
Address 1746 - K St. N.W. Washington, D.C. Date signed 11-28-46 M. D.

VS 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 11203140

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred: 1509 East West Hyway.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: SILVER SPRING.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1509 EAST WEST HIGHWAY
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Erwin Harold Wilson

3. (b) Social Security Number: 577-03-3980

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Kathryn S Wilson
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): June 22 - 1899

8. AGE: Years	Months	Days	If less than one day
47	4	17	....hrs. ....min.

9. Birthplace: SALT LAKE CITY - UTAH (Town, county, and state)
10. Usual occupation: SALESMAN. (BUSINESS MACHINES)
11. Industry or business

FATHER
12. Name: ERVIN - WILSON
13. Birthplace: UTAH.

MOTHER
14. Maiden name: UNKNOWN ELIZABETH M.
15. Birthplace: UNKNOWN. UTAH.

16. Informant: MRS KATHRYN - S. WILSON.
Address: 1509 EAST WEST HYWAY - SILVER SPRING

17. CREMATION. (Burial, cremation, or removal. Which?) Date thereof: NOV 11 - 1946 (month) (day) (year)
Cemetery or crematory: CEDAR HILL
Location: SUITLAND - PR. GEO'S CO. MD

18. Funeral director: Warner E. Pumphrey
Address: SILVER SPRING. MD.

19. NOV. 11 1946 (Date rec'd by registrar) Josephine M. Schaefle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9 1946 at 1 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 8 1946 to Nov 9 1946
and that I last saw h...alive on Nov 9 1946

	DURATION
Immediate cause of death: Myocardial infarction	4 hrs.
Due to: acute coronary occlusion	4 hrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: Injured at work?

23. SIGNATURE: H. J. Keaveny M.D. M. D. or other
Address: 7852 16th St NW Wash DC Date signed: 11/9/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1460

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 10:45 P.M. - 11-23-46

Hospital, Institution, or street address where death occurred:
Suburban Hosp. 8600 Old Georgetown Rd.

How long in hospital or institution? Since 10:45 - 11-23-46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Kensington, Md.,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3300 Ferndale Ave,
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mr. Louis Eugene Young

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Cora Young

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1873

8. AGE: Years	Months	Days	If less than one day
73	1	27	hrs. min.

9. Birthplace: Bath Ohio
(Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business

FATHER — 12. Name: Ira Young

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Ellen Shade

15. Birthplace: Sharon Center Ohio

16. Informant: Howard Young

Address: Lincoln, Delaware

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11/25/46 (month) (day) (year)

Cemetery or crematory: Milford, Delaware

Location: Delaware

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Md.

19. 11/25 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24-46 19.. at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 46 19.. to Nov. 24 1946 and that I last saw h.i.m. alive on Nov. 24 46 19..

Immediate cause of death	DURATION
Coronary Thrombosis	(about 7 hours)
Due to: Arteriosclerosis; generalized	undetermined
Coronary Sclerosis; severe	
Due to:	
Other conditions: Mitral Stenosis; moderate; coronary undetermined (Probably Rheumatic Basis)	undetermined

(Include pregnancy within 3 months of death)

Major findings of operations: No

Date of op.:

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel Allen M.D.
M. D. or other

Address: 14 Fawcett, Kensington, Md. Date signed: 11/24/46

VS-A15 9-46M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-a)

CERTIFICATE OF DEATH

2 ★ 11211

Reg. Dist. No. 2160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 7:45 P.M. 11/3/46
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5200 McArthur Blvd., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: EMMA STAUFFER ZIMMERMAN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband: Martin D.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 6th. 1891

8. AGE: Years	Months	Days	If less than one day
55	5	0	..... hrs. ..... min.

9. Birthplace: Lancaster Co. Penna. (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Silas W. Stauffer
13. Birthplace: Goodville, Pa.

MOTHER
14. Maiden name: Hetty Weaver
15. Birthplace: Goodville, Pa.

16. Informant: Mrs. Wallace R. Amos
Address: 103 Elm Ave. Kensington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 8th. 46 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Pr. Geo's Co. Md.
18. Funeral director: Wane & Pumphrey.
Address: Silver Spring, Md.

19. 11/7 1946 (Date rec'd by registrar) Jno E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 Nov 1946, at 9 15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 Sept 1946, to 5 Nov 1946.
and that I last saw her alive on 5 Nov 1946.

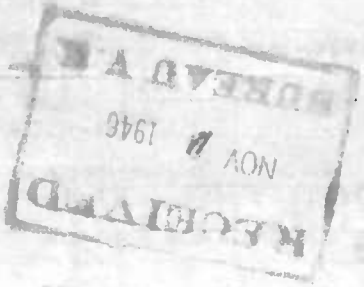
	DURATION
Immediate cause of death: Carcinoma of Kidney with metastasis	3+ mo
Due to: to Left Lung and abdominal viscera.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: A H Richmond MD. M. D. or other
Address: 5522 Western Ave / Chevy Chase, Md. Date signed: 6 Nov 46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-B

CERTIFICATE OF DEATH

1121

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 9 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1824 15th St., N. W., Apt. 1
(If rural, give LOCATION)

2.(a) If veteran, name war (S) 1st World War ✓

3. (a) FULL NAME ZOLLICOFFER, Walter (n)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Blk-US	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12 Feb. 1888

8. AGE: Years	Months	Days	If less than one day
58	9	17	..... hrs. ..... min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual occupation cook

11. Industry or business

FATHER 12. Name Charles Zollicoffer

FATHER 13. Birthplace N.C.

MOTHER 14. Maiden name Miranda Burton

MOTHER 15. Birthplace N. C.

16. Informant daughter, Mrs. Mary L. Ratteray

Address 547 Madison St., Brooklyn, N.Y.

17. removal Date thereof 11-30-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakgrove Church Cemetery

Location Littleton, North Carolina

18. Funeral director E. W. Jarvis

Address 1432 U. St. N.W. Wash. D. C.

19. 11-29 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Nov. 1946, at 8:12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 July 1946, to 29 Nov. 1946 and that I last saw him alive on 29 Nov. 1946

	DURATION
Immediate cause of death Carcinoma of Stomach.	1½ yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Marginal annular Carcinoma of Stomach & metastases to omentum & capsule of liver. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. E. GRANT, Comdr. (MC) USN
M. D. or other

Address USNH Bethesda, Md. Date signed 11-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

12/6/46

2-25

D. 2100 - 2210